

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25256**

FILED AUG 14 1950

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | | | | | |
|---|--|--|--|--|-------------------------|--|----------------------------------|
| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 6767 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | c. LENGTH OF STAY (In this place) 7 days | | c. CITY (If outside corporate limits, write RURAL and give township) Willisville | | 8120 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hosp. | | | | d. STREET ADDRESS (If rural, give location) 8 | | | |
| 3. NAME OF DECEASED a. (First) Carol b. (Middle) June c. (Last) Schoneberg | | | 4. DATE OF DEATH (Month) (Day) (Year) Aug 7, 1950 | | 5. SEX Female | | 6. COLOR OR RACE White |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never | | 8. DATE OF BIRTH July 28, 1950 | | 9. AGE (In years last birthday) If under 1 year: Months 10 Days _____ If under 24 hrs: Hours _____ Min. _____ | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Murphysboro, Ill. | | 12. CITIZEN OF WHAT COUNTRY? Amer | | 13a. FATHER'S NAME Ott Schoneberg | |
| 13b. MOTHER'S MAIDEN NAME E. Lucille McDintyre | | 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT'S SIGNATURE OR NAME | | | | ADDRESS | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Crochical atresia with fistula ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Empyema DUE TO (c) Mediastinitis | | | | INTERVAL BETWEEN ONSET AND DEATH 11 days 5 days 5 days | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION Repair of diaphragmatic fistula. 2nd OR - gastrostomy. | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 759, 3 | | 22. I hereby certify that I attended the deceased from 7-31 , 19 50 , to 8-7 , 19 50 , that I last saw the deceased alive on 8-7 , 19 50 , and that death occurred at 7⁰⁰ a.m. , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE Wm. Sklingberg M.D. | | | 23b. ADDRESS | | 23c. DATE SIGNED | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE | | 24c. NAME OF CEMETERY OR CREMATORY Peace Lutheran | | 24d. LOCATION (City, town, or county) (State) Steelville Ill | |
| DATE REC'D BY LOCAL REG. AUG 9 1950 | | REGISTRAR'S SIGNATURE J. B. Lester | | 25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service, Inc. St. Louis 10, Mo. | | | |

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Paul M. Simon

Signed.....
Student Embalmer

Licensed Embalmer No. *4343*

P. O. Address *St. Louis Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.