

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 4417

FILED JUN 9 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. \_\_\_\_\_

|   |                                   |  |      |
|---|-----------------------------------|--|------|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Missouri b. COUNTY St. Louis |      |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN St. Louis | c. LENGTH OF STAY (in this place) | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN Lemay  | 4860 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hoapital                                |                                   | d. STREET ADDRESS (If rural, give location)<br>8528 Idaho Ave  |      |

|  |                        |  |  |   |  |
|--|------------------------|--|--|---|--|
| 3. NAME OF DECEASED<br>(Type or Print) Elizabeth (Lizzie) Schillinger                                  |                        |  | 4. DATE OF DEATH (Month) (Day) (Year)<br>5-10-1951 |   |  |
| 5. SEX Female  | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2 | 8. DATE OF BIRTH 10-10-1886                        | 9. AGE (In years last birthday) 64                      | 10. UNDER 1 YEAR Months Days           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>At Home |                        | 10b. KIND OF BUSINESS OR INDUSTRY                              |  | 11. BIRTHPLACE (State or foreign country)<br>Missouri 0 | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME<br>Jacob Hoerner                                  | 13b. MOTHER'S MAIDEN NAME<br>Augusta Doersch | 14. NAME OF HUSBAND OR WIFE  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. None                 | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>Frank C. Schillinger 41 A. Wilmington Ave |

|  |   |  |
|--|---|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis<br>INTERVAL BETWEEN ONSET AND DEATH |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  | DUE TO (b) Arteriosclerosis   |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.  | DUE TO (c)  |  |

|  |  |   |
|--|--|---|
| 19a. DATE OF OPERATION                             | 19b. MAJOR FINDINGS OF OPERATION   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" 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?<br>332X  |

22. I hereby certify that I attended the deceased from 5-1, 1951, to 5-9, 1951, that I last saw the deceased alive on 5-8, 1951, and that death occurred at 2:00 A.M., from the causes and on the date stated above.

|   |   |   |   |
|---|---|---|---|
| 23a. SIGNATURE<br><i>W. Eades</i>                   | (Degree or title)                             | 23b. ADDRESS<br>7602 So. Broadway   | 23c. DATE SIGNED<br>5/10/51   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial | 24b. DATE<br>5-12-1951                        | 24c. NAME OF CEMETERY OR CREMATORY<br>Park Lawn Cemetery                        | 24d. LOCATION (City, town, or county) (State)<br>1800 Lemay Ferry Road Mo |
| DATE REC'D BY LOCAL HEALTH REG. 5-11-51             | REGISTRAR'S SIGNATURE<br><i>J. B. Lasater</i> | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><i>J. Egenheim</i> 6409 Gravois Ave |   |

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

7602 S. Broadway

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.....

*John M. Sigmon*

Signed.....  
Student Embalmer

Licensed Embalmer No. ....

*4343*

P. O. Address.....

*Adrian, 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.