

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **45239**  
**12373**  
Registrar's No.

**FILED JAN 19 1954**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST LOUIS,</b>		c. LENGTH OF STAY (In this place) c. CITY OR TOWN <b>ST. LOUIS</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4110 a RED BUD</b>		e. STREET ADDRESS (If rural, give location) <b>10 4110 a RED BUD AVE</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>FLORENCE</b>		b. (Middle)	c. (Last) <b>CHILL</b>
4. DATE OF DEATH <b>DEC, 30, 1953</b>	5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>
8. DATE OF BIRTH <b>12/19/1881</b>	9. AGE (In years last birthday) <b>72</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>ST LOUIS MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>LOUIS C ROBINS</b>		13b. MOTHER'S MAIDEN NAME <b>ANNA DRISCOLL</b>	
14. NAME OF HUSBAND OR WIFE <b>JACOB JAY CHILL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>ISABELLE SCHLUETER 4110 a RED BUD</b>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>arteriosclerotic Heart Disease</b> DUE TO (c) <b>Branchial pneumonia</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>8 yrs</b> <b>1 week</b>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4200</b>	
22. I hereby certify that I attended the deceased from <b>Dec. 15, 1951</b> , to <b>Dec. 30, 1953</b> , that I last saw the deceased alive on <b>Dec. 29, 1953</b> , and that death occurred at <b>12:50 p. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>John A. Carrier, M.D.</b>		23b. ADDRESS <b>462 N. Taylor - St. Louis, Mo.</b>	23c. DATE SIGNED <b>12/31/53</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>1/2/54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>	24d. LOCATION (City, town, or county) (State) <b>ST LOUIS MISSOURI</b>
DATE REC'D BY LOCAL REG. <b>DEC 31 1953</b>	REGISTRAR'S SIGNATURE <b>J. Gail Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>STROOT - CARROLL 4600 NATURAL BRIDGE AVE</b>	

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

*Dr. Carrion  
Pastor Bly  
to 2<sup>nd</sup>*

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *M W Ruetter*

Licensed Embalmer No. *4865*

P. O. Address *St Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.