

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17294**  
Registrar's No. **4238**

BIRTH NO. \_\_\_\_\_ 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>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <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 type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1143 S. Kingshighway Bl.</b>		e. STREET ADDRESS (If rural, give location) <b>1143 S. Kingshighway Bl.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>KATHERINE</b> b. (Middle) <b>***</b> c. (Last) <b>SCHILLER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May. 10, 1954</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, <b>WIDOW</b> WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>Dec. 26, 1877</b>	9. AGE (In years last birthday) <b>76</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>William Wichard</b>	13b. MOTHER'S MAIDEN NAME <b>Katherine Klein</b>	14. NAME OF HUSBAND OR WIFE <b>Late Max Schiller</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Florence Wichard-1143 S. Kingshighway</b>	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral embolism.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
	ANTECEDENT CAUSES	DUE TO (b) <b>Auricular fibrillation</b>	<b>10 days</b>
	Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (c) <b>Arterio-sclerotic heart disease</b>	<b>Not known</b>
	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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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>
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22. I hereby certify that I attended the deceased from **May 3, 1954**, to **May 10, 1954**, that I last saw the deceased alive on **May 9, 1954**, and that death occurred at **3:30 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>David S. Kieffer M.D.</b>	23b. ADDRESS <b>4500 Olive</b>	23c. DATE SIGNED <b>5/10/1954</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>5-12-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>MAY 11 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser-4228 S. Kingshighway Bl.</b>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

**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 *Richard W. Storza*.....

Licensed Embalmer No...400.....

P. O. Address.....

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.