

FILED APR 27 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **15031**

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>317</b>  |   | PRIMARY REG. DIST. NO. <b>541</b>  |   | Registrar's No. <b>923</b>   |   |  |
| 1. PLACE OF DEATH   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |   |  |   |  |
| a. COUNTY<br><b>St. Louis</b>   |  | b. CITY (If outside corporate limits, write RURAL and give town(ship))<br><b>Clayton</b>               |   | a. STATE<br><b>Missouri</b>  |   | b. COUNTY<br><b>St. Louis</b>  |   |  |
| c. LENGTH OF STAY (in this place)<br><b>20 years</b>  |  | c. CITY OR TOWN<br><b>Clayton 4452</b>   |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>421 Oakley Drive</b>  |  |  |   | e. STREET ADDRESS (If rural, give location)<br><b>421 Oakley Dr/</b>   |   |  |   |  |
| 3. NAME OF DECEASED (Type or Print)   |  |  | 4. DATE OF DEATH (Month) (Day) (Year)               |  |   |  |   |  |
| a. (First)<br><b>KATHERINE</b>  |  | b. (Middle)  |   | c. (Last)<br><b>SCHILLING</b>  |   | <b>April 9, 1956</b>   |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b>  |   | 8. DATE OF BIRTH<br><b>Nov. 14, 1871</b>                               |   |  |
| 9. AGE (In years last birthday)<br><b>84</b>  |  | IF UNDER 1 YEAR<br>Months <b>4</b> Days <b>25</b>  |   | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>   |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Never Worked</b>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b> |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Illinois</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13a. FATHER'S NAME<br><b>Louis Schilling</b>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Bridget Keating</b> |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>None</b>                             |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Mrs. Frank Franey, 421 Oakley Dr. Clayton</b>  |   |  |   |  |
| 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, asthma, etc. It means the disease, injury, or complication which caused death.   |  | MEDICAL CERTIFICATION  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)  |  | <b>Myocardial infarction</b>   |   |  |   |  | <b>1 week</b>   |  |
| ANTECEDENT CAUSES   |  | DUE TO (b) <b>Hypertensive H.D.</b>  |   |  |   |  | <b>?</b>  |  |
|   |  | DUE TO (c) <b>Arteriosclerotic H.D.</b>  |   |  |   |  | <b>?</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?<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?   |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>10-18</b> , 19 <b>56</b> , to <b>11-9</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>11-8</b> , 19 <b>56</b> , and that death occurred at <b>7 A</b> m., from the causes and on the date stated above. |  |  |   |  |   |  |   |  |
| 23a. SIGNATURE (Degree or title)<br><b>Herbert B. Dombro</b>  |  |  |   | 23b. ADDRESS<br><b>2505 Delmas</b>   |   | 23c. DATE SIGNED<br><b>4-10-56</b>                                     |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |  | 24b. DATE<br><b>4/12/56</b>  |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>  |   | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b> |   |  |
| DATE REC'D BY LOCAL REG.<br><b>4-10-56</b>  |  | REGISTRAR'S SIGNATURE<br><b>Herbert B. Dombro</b>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Louis H. Bopp</b>   |   | ADDRESS<br><b>Keithwood</b>  |   |  |

(Licensed Embalmer) Statement on Reverse Side

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

300  
48

**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 *Felix Durand*.....

Licensed Embalmer No *2234*

P. O. Address *Kentwood*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.