Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003878
STATE FILE NUMBER

FILED FEB 11 1958 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 239

1. PLACE OF DEATH a. COUNTY St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Richmond Hts. Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Richmond Hts. 4495 0 Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Mary's Hosp. Length of stay in 1b 1 Month	d. STREET ADDRESS (If outside, give location) 1119 Edward Terrace Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)	First MILDRED	Middle	Last SCHIKORE	4. DATE OF DEATH Month Jan. Day 26 Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐	8. DATE OF BIRTH May 18,1904	9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-T. S. & Maintenance Command	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) U.S.Army Griffin, Ind.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Christian Hornbostel	13b. MOTHER'S MAIDEN NAME Marguerite Schwartz		14. NAME OF HUSBAND OR WIFE Late Herbert C. Schikore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 499-28-3167		17. INFORMANT Address Roland Schikore 1119 Edward Tr.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic carcinoma	6 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Adenocarcinoma of uterus	1 yr.
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 174X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Dec 1958, to Jan 26,1959 and last saw her/him alive on Jan 25, 1959
Death occurred at 5:00 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wm. C. Macdonald M.D.	22b. ADDRESS 4161 Lindell	22c. DATE SIGNED 1.26.59
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE Jan.28,1959	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory
23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		
24. FUNERAL DIRECTOR Kriegshauser	ADDRESS 4228 S.Kingshighway	25. DATE RECD. BY LOCAL REG. 1.26.59
26. REGISTRAR'S SIGNATURE John C Murphy, MD		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. .....

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.