

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015676

STATE FILE NUMBER

FILED APR 24 1959

Registration District No.

Primary Registration District No.

Registr. No. **3391**

300  
-57

75

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, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony Hosp.</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>3238a Pulaski</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Schillinger</b>			4. DATE OF DEATH Month Day Year <b>4 April 1959</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 4, 1959</b>
9. AGE (In years last birthday)	10. FUNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	<b>55</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Robert J. Schillinger</b>	
13b. MOTHER'S MAIDEN NAME <b>Rita Hagerty</b>		14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Robert B. Schillinger 3238a Pulaski</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>anemia due to placental insufficiency -</b> <b>scarred placenta @ circumbilicate type.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Extensive hematocrity (stark) 761.5</b> DUE TO (c) <b>Extensive hematocrity (stark) 761.5</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>none</b>		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK 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 <b>Birth 4/4/59 3:55 am</b> to <b>4/4/59 4:50 am</b> and last saw him alive on <b>4/4/59</b> Death occurred at <b>450 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>W. M. Shaw M.D.</b> (Degree or title)		22b. ADDRESS <b>3804 W. Livingston Ave</b>	22c. DATE SIGNED <b>4/6/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>4-6-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>	23d. LOCATION (City, town, or county) (State) <b>Lemay 23, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 6 '59</b>	26. REGISTRAR'S SIGNATURE <b>J. G. Good Smith, M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

*der Notowa*

**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 *David Van Fossen* .....

Licensed Embalmer No. *1242* .....  
P. O. Address *St Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.