

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017773

FILED VS APR 29 1960

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 155 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		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>Brentwood</b>		Length of stay in 1b <b>18 mos</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Gould-Worth Conv, Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>6621 Wise</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>EUGENIA SCHILDKNECHT</b>			4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/1873</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>France</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>unk Edelmann</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Leo Schildknecht</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>unk.</b>	17. INFORMANT <b>Henry F. Shield, 643 Oak Valley</b>
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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) <b>Cerebral Hemorrhage</b>		<b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized arteriosclerosis</b>	<b>3 yrs</b>
	DUE TO (c) <b>331X</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Senile dementia</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
20c. TIME OF INJURY Hour <b>5:55</b> a.m. p.m.	Month, Day, Year <b>2-1-59</b>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Mo.</b>
21. I attended the deceased from <b>2-1-59</b> to <b>3/28/60</b> and last saw her alive on <b>3/28/60</b> Death occurred at <b>5:55 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <i>E. Edelmann</i>	(Deceased or title)	22b. ADDRESS <b>Kirkwood 21. Mo</b>	22c. DATE SIGNED <b>3/28/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>March 30, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b>	23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b>

24. FUNERAL DIRECTOR <b>BEIDERWIEDEN F.H., Inc., 1936 St. Louis Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>3-29-60</b>	26. REGISTRAR'S SIGNATURE <i>J. C. Murphy</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 45

P. O. Address \_\_\_\_\_

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