

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 3 1960

-60-038818

Registration District No. 160 Primary Registration District No. 559 Registrar's No. 139

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>DEKARSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>170</u> b. COUNTY <u>St. Genevieve</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joachim Township</u>		Length of stay in 1b <u>30 Days</u>		c. CITY OR TOWN <u>Bloomsdale 170</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>DeKearson County Memorial</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Bloomsdale 170</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSINA Sophie Schilly</u>				4. DATE OF DEATH Month Day Year <u>Oct 26 1960</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3-29-1877</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Zell, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>Joseph Basler</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Ann Schweiss</u>		14. NAME OF HUSBAND OR WIFE <u>Francis X. Schilly</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Bernard Schilly Bloomsdale 170</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO (b) <u>Post-operative</u> DUE TO (c) <u>Fracture right hip - hip neck</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs</u> <u>3 weeks</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</u>							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				
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.) <u>Fall on, nursery home</u>							
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			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.) <u>Nursing home</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>St. Genevieve Mo</u>	
21. I attended the deceased from <u>9-28-60</u> to <u>10/26/60</u> and last saw her/him alive on <u>7 PM</u>				Death occurred at <u>1:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>[Signature]</u> (Degree or title)				22b. ADDRESS <u>Box 146 Crystal City Mo</u>			22c. DATE SIGNED <u>10/28/60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10-28-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Philomena</u>		23d. LOCATION (City, town, or county) (State) <u>Bloomsdale Mo</u>						
24. FUNERAL DIRECTOR <u>James A. Trotter St. Genevieve Mo</u>			25. DATE RECD. BY LOCAL REG. <u>10/28/60</u>		26. REGISTRAR'S SIGNATURE <u>John N. Hull Deputy</u>						

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed *Joseph L. Siano*

Licensed Embalmer No. 3817

P. O. Address *St. Genevieve*

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