

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-009507

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 10

FILED FEB 19 1962

VS 300 Rev. 4/59	DATE AMENDED
0950	
8951	
3	
4 0	
5 2	
6	
7 0	
8 2	
9 181.0	
10	
11	
12 96-0	
13 1-0	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>STE. GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. GENEVIEVE</u>		Length of stay in 1b <u>50 YRS</u>	c. CITY OR TOWN <u>STE. GENEVIEVE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>STE. GENEVIEVE HRET HOME</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>183 N. MAIN ST</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>FRANCIS</u> Last <u>SCHILLY</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>13</u> Year <u>1962</u>
5. SEX <u>MALE</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>8/16/80</u>
9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CITY MARSHAL (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>WEINGARTEN MO</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>HEINRICH SCHILLY</u>	
13b. MOTHER'S MAIDEN NAME <u>REGINA BASLER</u>		14. NAME OF HUSBAND OR WIFE <u>MARY GRASE</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>Tabrian S. Schilly 10, Greener Mo</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>Carcinoma of Urinary Bladder</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____	
		DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>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 checked="" type="checkbox"/> NO <input 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 _____ 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.) _____	20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____
21. I attended the deceased from <u>Dec 28, 1944</u> to <u>Feb 13, 1962</u> and last saw ^{her} him alive on <u>Feb 12, 1962</u> Death occurred at <u>11:05</u> <u>P</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Alb. Lanning M.D.</u> (Degree or title)		22b. ADDRESS <u>St. Genevieve Mo.</u>	22c. DATE SIGNED <u>2/15/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) _____	23b. DATE <u>2/16/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALLE SPRING</u>	23d. LOCATION (City, town, or county) <u>St. Genevieve Mo</u> (State) _____
24. FUNERAL DIRECTOR <u>Gene. Sachse, Greener Mo</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>15 February 1962</u>	26. REGISTRAR'S SIGNATURE <u>George F. Wood</u>

FEB 26 1962

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 Adrian J. Ehler

Licensed Embalmer No. 4740

P. O. Address Ste Genevieve 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.