

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REC'D AUG 11 1939

23719
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **Josephine Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Joseph Charles Schilling**

(a) Residence, No. **567 N. 27th. St** St. **NR** **East St. Louis, Ill**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Mary Cosgrove**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **April 19, 1879**

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
60 2 17

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Salesman**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Pinkneyville Ill**

FATHER 13. NAME **Joseph Schilling**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo**

MOTHER 15. MAIDEN NAME **Catherine Decker**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

17. INFORMANT (ADDRESS) **Chas Schilling East St. Louis, Ill**

18. BURIAL, CREMATION, OR REMOVAL PLACE **East St. Louis Ill** DATE **July 10, 1939**

19. FUNERAL DIRECTOR (ADDRESS) **Chas Schilling East St. Louis, Ill**

20. FILED **JUL 7 1939** **J. D. Budeck** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **July 6, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **Jan 6, 1939, to June 6, 1939.**
 I last saw him alive on **June 6, 1939** Death is said to have occurred on the date stated above, at **11:50 P**
 The principal cause of death and related causes of importance were as follows:

Jan 6/39 Chronic, interstitial nephritis
6/18/39
 Other contributory causes of importance: *Acute myocarditis*
6/18/39

Name of operation *None* Date of *None*
 What test confirmed diagnosis? *None* Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *None* Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *None*
 If so, specify (Signed) *Stephen J. ... M. D.* (Address) *3202 ...*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I, Chas. M. Burke Licensed Embalmer No. 2421

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Chas. M. Burke

L. E.

No. _____ or by _____ Registered Apprentice No. _____

working under my personal supervision.

Signed

Chas. M. Burke

Licensed Embalmer No. 2421

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.)