

10. 2  
-13.40  
-17.39  
X22159

Registration District No. 791 Primary Registration District No. 1003 State File No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED DEC 11 1940

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Louis City Hospital #1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 Days  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town Saint Louis, 24  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2844 Lyon Street.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Marie Schiller  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month October day 30,  
year 1940 hour 4:35 minute \_\_\_\_\_ P. A. M.  
21. I hereby certify that I attended the deceased from October 28,  
19 40 to October 30, 19 40  
that I last saw her alive on October 30, 19 40  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed.  
6. (b) Name of husband or wife John Schiller 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased September 12th, 1872.  
(Month) (Day) (Year)

Immediate cause of death Diabetes Mellitus  
Abscess of neck.

8. AGE: Years Months Days If less than one day  
68 1 19 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Unknown Austria.  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name Unknown

13. Birthplace Unknown Austria  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown Austria  
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth Wolf

(b) Address 2844 Lyon Street.

17. (a) Burial (b) Date thereof Nov. 2nd, 40.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director J. J. Schiller

(b) Address 2623 Cherokee Street.

19. (a) NOV 1 1940 (b) \_\_\_\_\_  
(Date received local registrar) (Date received)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy Abscess of neck

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature Wm H. Schiller (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette Ave. Date signed 10/30/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

3178

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed W E Morris

Licensed Embalmer No. 3360

P. O. Address 2623 Clerk

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

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