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4-17-3  
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NOV 15 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 11868

Registration District No. 760 B

Primary Registration District No. 6001

Registrar's No. 134

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town O'Fallon, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Institute  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years.

3. (a) PRINT FULL NAME Sister Mary Evangelista Schilli

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July, 1937, to Feb. 12, 1941;  
that I last saw her alive on Feb. 12, 1941;  
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 Single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Day) (Year)

7. Birth date of deceased Oct 19 1884  
(Month) (Day) (Year)

Immediate cause of death Myocarditis

Due to Hypostatic pneumonia

Duration 5 yrs.  
24 hrs.

8. AGE:

Years	Months	Days	If less than one day
<u>56</u>	<u>3</u>	<u>7</u>	hr. min.

9. Birthplace Heingarten Mo.  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

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

10. Usual occupation Teaching

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

MOTHER FATHER

12. Name Henry Schilli

13. Birthplace Zell Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Donga

15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Sister M. Berchmans

(b) Address O'Fallon, Mo.

17. (a) Burial (b) Date thereof Feb. 15, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation O'Fallon, Mo.

18. (a) Signature of funeral director H. C. Gallmeyer & Sons

(b) Address 800 N. Second, St. Charles, Mo.

19. (a) March 11 - 41 (b) E. A. Kuehly  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Nicholas J. Houck (M. D. or other) \_\_\_\_\_

Address O'Fallon, Mo. Date signed 2-14-41

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

100

1309

**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..... *John E. Dellmeyer* .....

Licensed Embalmer No. *0951* .....

P. O. Address..... *St Charles 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 this body is not embalmed, fact should be so stated above.**

Registration District No. 76013

Primary Registration District No. 6001

Registrar's No.

1. PLACE OF DEATH

(a) County St Charles  
(b) City or town Barstow T.P.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sister Mary Evangelista Schilli

MEDICAL CERTIFICATION

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Feb day 12  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ year \_\_\_\_\_

Myocarditis

7. Birth date of deceased: (Month) (Day) (Year)

Due to Hypostatic pneumonia

8. AGE: Years 76 Months 3 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Bronchial

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

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

10. Usual occupation \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

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

12. Name \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

22. If death was due to external causes, fill in the following:

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? \_\_\_\_\_

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

(b) Address \_\_\_\_\_

23. Signature Nicholas J. Honick (M. D. or other) \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

Address O'Fallon, Mo. Date signed 6-9-41

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

SUPPLEMENTAL

436

PHYSICIAN  
Underline the cause to which death should be charged statistically.

11868