DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 23 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8504

Registration District No. 333 Primary Registration District No. 3074 Registrar's No.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 505 N. Kingshighway 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 40 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Scott 100
(c) City or town Sikeston Mo 5
(If outside city or town limits, write "RURAL") 2
(d) Street No. 505 N. KINGSHIGHWAY
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country — 0

3. (a) PRINT FULL NAME FREDERICK CLARENCE SCHILLIG
3. (b) If veteran, name war
3. (c) Social Security No. —
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan 26 (Month) 1892 (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
51	10	16	hr. min.

9. Birthplace Nevada (City, town, or county) Mo 0 (State or foreign country)
10. Usual occupation None
11. Industry or business
FATHER
12. Name Frederick C. Schillig
13. Birthplace St Louis (City, town, or county) Mo 0 (State or foreign country)
MOTHER
14. Maiden name Emma Wark
15. Birthplace Unknown (City, town, or county) 4 (State or foreign country)
16. (a) Informant Sid Schillig
(b) Address Sikeston Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-43 (Month) (Day) (Year)
(c) Place: burial or cremation Sikeston Mo
18. (a) Signature of funeral director Welsh Funeral Home
(b) Address Sikeston Mo
19. (a) 2/16/44 (Date received local registrar) (b) Louie Largent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12 year (1943) hour 1 minute 30 P. M.
21. I hereby certify that I attended the deceased from December 12, 1943 to December 12, 1943 that I last saw him alive on December 12, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar Pneumonia	30 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

108

Major findings:
Of operations
Of autopsy

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

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 2
23. Signature H. C. Huber (M. D. or other) D.O.
Address Sikeston, Missouri Date signed 12-31-43

1318 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Office No. 2
District File Number 244-34
Date Filed 2-21-49

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.....

Licensed Embalmer No.....

P. O. Address.....

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

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

. 2B
5-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 323 Primary Registration District No. 3074 Registrar's No.

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston
(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 years, months or days)
In this community

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 Frederick C. Schilling
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan 26 1882 (Month) (Day) (Year)

8. AGE: Years 51 Months 10 Days 16 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 12 year 1943 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.
Immediate cause of death — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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

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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

8504