

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35305
State File No.
Registrar's No. 8252

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Florida b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jacksonville, 8090		d. STREET ADDRESS (If rural, give location) unknown 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3714a Maffitt Ave.,			

3. NAME OF DECEASED (Type or Print)	a. (First) EMMA	b. (Middle) YOUNG	c. (Last) SCHILLING.	4. DATE OF DEATH (Month) (Day) (Year) Sept. 29 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 24 1899	9. AGE (In years last birthday) 51	# UNDER 1 YEAR Months	# UNDER 1 RES. HOUR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary;	10b. KIND OF BUSINESS OR INDUSTRY unk	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Harry Young.	13b. MOTHER'S MAIDEN NAME Jennie Elliman.	14. NAME OF HUSBAND OR WIFE Frank Schilling.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. unk	17. INFORMANT'S SIGNATURE OR NAME Harvey A. Golden;	ADDRESS 3714a Maffitt,
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 weeks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HPTZ
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22. I hereby certify that I attended the deceased from Sept 9, 1950 to Sept 29, 1950, that I last saw the deceased alive on Sept 29, 1950, and that death occurred at 9:00 AM, from the causes and on the date stated above.

23a. SIGNATURE W. J. Brown M.D.	(Degree or title)	23b. ADDRESS 3903 Glen	23c. DATE SIGNED 9/29/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE Oct. 3 1950	24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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DATE REC'D BY LOCAL REG. SEP 30 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE C.R. Lupton & Sons;	ADDRESS 7233 Delmar Blvd
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Handwritten initials

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Arnold W. Schoene

Signed.....
Student Embalmer

Licensed Embalmer No. 3864

P. O. Address St. Louis, 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.