

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010647

STATE FILE NUMBER

LED APR 7 1959

Registration District No. 316

Primary Registration District No. —

Registrar's No. 127

5. 300
1-57

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1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural-St. Francois Twp.		c. CITY OR TOWN AFFTON MO	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hosp. #4		d. STREET ADDRESS (If outside, give location) 17Y, 3Mo, 22days	
3. NAME OF DECEASED (Type or print) First OLIVIA Middle MARY Last SCHILLY		4. DATE OF DEATH Month MAR Day 22 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 19 1898 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) STE GENEVIEVE MO
13a. FATHER'S NAME GRAFTON HICKARD		13b. MOTHER'S MAIDEN NAME AMANDA KALUMONIER	14. NAME OF HUSBAND OR WIFE JOHN C. SCHILLY
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.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ignition due to psychosis		17. INFORMANT Address John C Schilly 5200 Vine Affton Mo	
DUE TO (b) Dementia Praecox, Catatonic type		INTERVAL BETWEEN ONSET AND DEATH about one month	
DUE TO (c) 3002,		about 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) None	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. None			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1957 intermittently to 3-22-1959 and last saw her him alive on 3-22-59 Death occurred at State Hospital #4 on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John Brennan M.D.		22b. ADDRESS State Hospital #4 Farmington, Missouri	
		22c. DATE SIGNED 4-2-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/25/59	23c. NAME OF CEMETERY OR CREMATORY VALLE SPRING	23d. LOCATION (City, town, or county) (State) STE GENEVIEVE MO
24. FUNERAL DIRECTOR Rec. Sashy St. Genevieve Mo		25. DATE RECD. BY LOCAL REG. Apr. 2, 1959	26. REGISTRAR'S SIGNATURE Esther Rudloff

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

MS APR 14 1956

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *William J. Ehlert*

Licensed Embalmer No. *4740*

P. O. Address *St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.