

VS JAN 16 1961

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STATE FILE NUMBER 3625

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

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony Hosp.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8419 S. Broadway</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Anthony J.</b> Middle <b>Schillinger</b> Last			4. DATE OF DEATH Month <b>Jan.</b> Day <b>8,</b> Year <b>1961</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1887</b>	9. AGE (last birthday) <b>73</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. 4 yrs. Photo Engraver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Anthony Schillinger</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Bischoff</b>		14. NAME OF HUSBAND OR WIFE <b>Marie G. Schillinger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Marie G. Schillinger 8419 S. Brdy.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arterio sclerotic heart disease 3 yrs</b> DUE TO (c) <b>with myocardial damage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>Jan. 1957</b> to <b>Jan 8, 1961</b> and last saw him alive on <b>Jan. 8-1961</b> Death occurred at <b>515 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>George A. O' Sullivan, M.D.</b>			22b. ADDRESS <b>7629 Groovy Ave.</b>		22c. DATE SIGNED <b>1-9-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>1-11-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Lemay, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Southern Funeral Home 6322 S. Grand, St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 10 1961</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith. M.D.</b>	

*Mr J Sullivan*

**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 *David Van Trossan*

Licensed Embalmer No. *4342*

P. O. Address *21 Linn St*

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.