

**MISSOURI STATE BUREAU OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

41179

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
Township..... Primary Registration District No. **1003**  
City..... (No. **4963**, **Thrush Ave**)

File No.....  
Registered No. **11845**  
St..... Ward.....

**2. FULL NAME**

*Louise Schneider*  
(a) Residence. No. **4963 Thrush** St., **4** Ward.  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Harry N. Schneider*  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *8-5-1883*  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *47 4 12*  
8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Housewife* **59**  
(b) General nature of industry, business, or establishment in which employed (or employer) **931**  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Louis*  
(STATE OR COUNTRY) *Mo.*

10. NAME OF FATHER *Louis Sachwitz*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Germany*  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Minnie Claus*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Germany*  
(STATE OR COUNTRY)

14. INFORMANT *Harry N. Schneider*  
(Address) *4963 Thrush Ave*

15. FILED *19* *May 1930*  
REGISTRAR *C. J. Stankoff*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 17* 19*30*

17. I HEREBY CERTIFY, That I attended deceased from *May*, 19*29*, to *12-17*, 19*30*, that I last saw her alive on *12-17*, 19*30*, and that death occurred, on the date stated above, at *7.40 P.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Malignant Hypertension*  
*Chronic Myocarditis*  
*Chronic Glomerulonephritis*  
*Hemiplegia Apoplectic* (duration) *2* yrs. mos. ds.  
CONTRIBUTORY *Diabetes Mellitus* (SECONDARY) (duration) *3* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH *Do not know*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF *-*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS *Blood Urea Nitrogen*  
(Signed) *H. J. [Signature]* M. D.  
*12-18, 1930* (Address) *437 Union Club Bldg*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Walvray Cem.* DATE OF BURIAL *12-20 1930*

20. UNDERTAKER *H. A. Stock and Co* ADDRESS *2117 E. Grand*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A STATISTICAL RECORD

A. E. Stanton

12<sup>30</sup> to 3

Union Creek Bluff

Jeff. 5946