

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.

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

Do not use this space.

MAY 13 1935

14759

FRB

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis Mo** (No. **Barnew Hospital**)

File No.....
Registered No. **3597**
St..... Ward.....

2. FULL NAME **Helen Marie Schneider**

(a) Residence, No. **4518 San Francisco St.** Ward. **St. Joseph Mo**
(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) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) can't know		
7. AGE YEARS abt 23	MONTHS	DAYS
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Candies		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. retail		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joe Mo		

OCCUPATION	13. NAME Fred Schneider
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
MOTHER	15. MAIDEN NAME can't know
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) can't know
17. INFORMANT Rob Haged Schneider (ADDRESS) 6024 Hazel St	
18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joe Mo DATE Apr 27 1935	
19. UNDERTAKER Thos J. Finlay (ADDRESS) 1519 Grand Blvd	
20. FILED APR 22 1935 J. Brebeck Registrar.	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **4-21-1935**

22. I HEREBY CERTIFY, That I attended deceased from **1-25-1935** to **4-21-1935**
I last saw h. **alive** on **4-21-1935**. Death is said to have occurred on the date stated above, at **3:15 a** m.
The principal cause of death and related causes of importance were as follows:
Pneumonia, broncha, et Date of onset **4-18-35**
F
23
Other contributory causes of importance:
Pulmonary tuberculosis **3 yrs**

Name of operation **Thoracoplasty, left** Date of **4-17-35**
What test confirmed diagnosis? **Autopsy** Was there an autopsy? **ye**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify _____
(Signed) **Fay S. Conner**, M. D.
(Address) **Barnew Hospital**

