

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

FEB 12 1938

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

1170
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **Park Lane Memorial Hospital** Registered No. **1026**
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Charles F. Schneider 536
 (a) Residence, No. **3118a N. 19th. St.** St. **26**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 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 **Anna Schneider**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July, 8-1891.**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
46 6 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Insurance Man**
 9. Industry or business in which work was done, as saw mill, bank, etc. **Metro. Life Ins.**
 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. Louis, Mo.**

FATHER 13. NAME **Otto Schneider**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

MOTHER 15. MAIDEN NAME **Anna Bohler**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Switzerland**

17. INFORMANT **Anna Schneider**
 (ADDRESS) **3118a N. 19th. St.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **New St. Marcus** DATE **Jan. 29th. 1938**

19. FUNERAL DIRECTOR **Wacker-Helderle**
 (ADDRESS) **2331 S. Broadway**

20. FUNERAL **JAN 28 1938** **J. J. Brebeck**
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 27th. 1938**

22. I HEREBY CERTIFY, That I attended deceased from

....., 19..... to **Jan. 26, 1938**
 I last saw him alive on **Jan. 26, 1938** Death is said to have occurred on the date stated above, **2.50 A.M.**

The principal cause of death and related causes of importance were as follows:

Pneumococcus meningitis 3rd type
7 y 8
 Date of onset

Other contributory causes of importance:
~~Acute arthritis, etc.~~
~~Water in City Hosp. later taken home~~

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury 1938

Where did injury occur? **Natural Death**
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **Death**
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify **None**
 (Signed) **Anna J. Smith**, M. D.
 (Address) **3624 S. Broadway, City.**

STATEMENT BY LICENSED EMBALMER

I, Robert Wheeler Licensed Embalmer No. 2128

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. 2128 or by _____ Registered Apprentice No. _____
working under my personal supervision.

Signed Robert Wheeler

Licensed Embalmer No. 2128

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

Vertical text on the right edge of the page, including "Alabama Board of Health" and "Alabama State Board of Health".

SUPPLEMENTARY

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

Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No.
 (b) Township Primary Registration District No. Registered No. 1026
 (c) City (d) Street No. Park Lane Memorial Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME. Charles F. Schneider

(a) Residence, No. 3118a N. 19th. St. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 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 Anna Schneider

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July, 8-1891.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
46 6 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Insurance Man
 9. Industry or business in which work was done, as saw mill, bank, etc. Metro. Life Ins.
 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. Louis, Mo.

FATHER 13. NAME Otto Schneider

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

MOTHER 15. MAIDEN NAME Anna Bohler

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

17. INFORMANT Anna Schneider
 (ADDRESS) 3118a N. 19th. St.

18. BURIAL, CREMATION, OR REMOVAL PLACE New St. Marcus DATE Jan. 29th 1938

19. FUNERAL DIRECTOR (NAME) Wacker-Helderle
 (ADDRESS) 2331 S. Broadway

20. FILED MAR. 18. 1938 J. J. Bedeck
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 27th. 1938

22. I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1938 to Jan. 27, 1938

I last saw him alive on Jan. 26, 1938. Death is said to have occurred on the date stated above, at 2:50 A. M.

The principal cause of death and related causes of importance were as follows:

Pneumonia
Measles

Date of onset

Other contributory causes of importance:

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?

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?

If so, specify Pneumonia, M. D.
 (Signed) J. J. Bedeck
 (Address) 1930 N. 19th St.

item of information. AGE should be stated EXACTLY. PHYSICIANS should state DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-1170

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.