

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

32367

Do not use this space.

1. PLACE OF DEATH

(a) County Gasconade Registration District No. 307
 (b) Township Boulware Primary Registration District No. 5425 Registered No. _____
 (c) City _____ (d) Street No. _____ 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 0 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Henry J. Schneider

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary Schneider
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 8, 1849
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
90 5 20
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. Farm
 10. Date deceased last worked at this occupation (month and year) 1922 11. Total time (years) spent in this occupation 55

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 28 1939

22. I HEREBY CERTIFY, That I attended deceased from March 25, 1939 to Aug 28, 1939
 I last saw him alive on Aug 25, 1939 Death is said to have occurred on the date stated above, at 10:30 p.m.
 The principal cause of death and related causes of importance were as follows:

March 28 left with hemiplegia and Aug 28 stroke side hemiplegia

Other contributory causes of importance: _____

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

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? Yes
 If so, specify John Engelbrecht (Signed) _____, M. D.
 (Address) Stony Hill, Mo

12. BIRTHPLACE (CITY OR TOWN) Bay (STATE OR COUNTRY) Missouri

FATHER 13. NAME Henry W. Schneider

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

MOTHER 15. MAIDEN NAME Huenke

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

17. INFORMANT Henry A. Schneider (ADDRESS) Bay, Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE Bay Zion Cem. DATE 8/30 1939

19. FUNERAL DIRECTOR (NAME) Hugo H. Blumer (ADDRESS) Hermann, Mo

20. FILED 8-30- 1939 Mrs. F. B. Meyer Local Registrar.

THIS IN plain-terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

822

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 *Megast Blument*
.....
- Licensed Embalmer No. 3160.....

P. O. Address Hermann, Mo.....

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

If this body is not embalmed, above space should be left blank.

47.
STATE OF MISSOURI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF HEALTH OFFICERS
ST. LOUIS, MISSOURI

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

323677
Do not use this space.

1. PLACE OF DEATH
 (a) County Gasconade Registration District No. 307
 (b) Township Boulware Primary Registration District No. 3425- Registered No.
 (c) City..... (d) Street No..... 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 Henry J. Schneider
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Mar

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
90 5 20

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19.....

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-28-1959

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.
 The principal cause of death and related causes of importance were as follows:
Left side Hemiplegia
Right side Hemiplegia
Due to central hemorrhage
 Other contributory causes of importance 87A'

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 (Signed) John Engelbrecht, M. D.
 (Address) St. Louis, Mo.

SUPPLEMENTARY

REGISTERED SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-32367