

E9372

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34036

NOV 13 1939 791
Registration District No.

Primary Registration District No.

Registrar's No. 8574

1. PLACE OF DEATH: 1003

(a) County 1

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
City Hospital, #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days
(Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME Mathilda Schneider 536

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wm. G. Schneider 6. (c) Age of husband or wife if alive 67 years

7. Birth date of deceased April 26, 1980
(Month) (Day) (Year)

8. AGE: Years 59 Months 5 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Louisville Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Bauer 6

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mathilda S. Schneider

(b) Address 3949 Russell Blvd.

17. (a) Removal (b) Date thereof Oct. 6, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Louisville, Kentucky

18. (a) Signature of funeral director Waick Bros.

(b) Address 2201 So. Grand Blvd.

19. (a) OCT 9 1939 (b) J. P. [Signature]
(Date received local registration) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3949 Russell
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5, year 1939 hour 12:30 minute _____ A. M.

21. I hereby certify that I attended the deceased from October 3, 1939 to October 5, 1939; that I last saw her alive on October 5, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular of liver
haemorrhage

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: MX

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Geo. W. Pike (M. D. or other) _____

Address 1515 Lafayette Date signed 10/5/39

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

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.

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.....

John Hutter

Licensed Embalmer No. 3880

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.