

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.

JAN 12 1940 781

State File No. _____
Registrar's No. 10719

Registration District No. 1000 Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County 2
(b) City or town St. Louis,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3010-a Nebraska Avenue,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 70 in St Louis (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St Louis 24
(If outside city or town limits, write "RURAL")
(d) Street No. 3010-a Nebraska Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME MATHILDA SCHNEIDT 530
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 14
year 1939 hour 8 minute 30 P. M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife George Schneidt 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 30 1862
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 11th, 1939, to Dec. 14, 1939, that I last saw her alive on Dec. 14, 1939, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
77 5 14 _____ hr. _____ min.

Immediate cause of death Cerebral hemorrhage Duration _____

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

Other conditions arterial sclerosis.
(Include pregnancy within 8 months of death)

10. Usual occupation Garment cleaner

Due to _____
Due to _____

11. Industry or business _____

Major findings:
Of operations _____
Of autopsy _____

MOTHER FATHER { 12. Name Joseph Gondolf 6
13. Birthplace Germany 5
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 14. Maiden name Mary Keating
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence none
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant's own signature Amelia White
(b) Address 3010-a Nebraska Avenue

17. (a) Cremation (b) Date thereof Dec. 16, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Thos. Rutis
(b) Address 2906 Gravois
19. (a) DEC 15 1939 (b) J. J. Brundage
(Date received local registrar) (Registrar's Signature)

While at work? _____ (Specify type of place)
(e) Means of injury _____
28. Signature Mrs. R. Nye (M. D. or other)
Address 2931 Gravois av. Date signed _____

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.....

Thor Lutis

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Thor Lutis

Licensed Embalmer No.....

1619

P. O. Address.....

2906 Gooies St

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!