

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.

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 1019

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of town or place)
 (c) Name of hospital or institution: DePaul Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 11 Days
 (Specify whether _____)
 In this community _____
 years, months or days

3. (a) ³⁻²⁶ PRINT FULL NAME George C. Schneider Jr.

3. (b) If veteran, name war None 3. (c) Social Security No. 493-03-7248

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.

6. (b) Name of husband or wife Wilma 6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased August 23 1916
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>5</u>	<u>7</u>	hr. _____ min.

9. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Wagner Electric Co.

12. Name George C. Schneider

18. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Jane Parish

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

16. (a) Informant's own signature Wilma Schneider

(b) Address 4716a Ashland Ave.

17. (a) Burial (b) Date thereof 2-3-48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Celvary

18. (a) Signature of funeral director Arthur J. Donnelly

(b) Address 3840 Lindell Blvd.

19. (a) FEB 1 1940 (b) _____
 (Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4716a Ashland Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 30
 year 1940 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 28-40
 _____, 19____, to Jan 30-40, 19____;
 that I last saw him alive on Jan 30-40, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Acute intestinal obstruction
gangrene of bowel
 Due to _____ Duration 4-6 days

Secondary to operation
in acute appendicitis at ab
 Other conditions Hospital Jan 16-40
 (Include pregnancy within 3 months of death)

Major findings: Gangrene of ileum
 Of operations _____

Of autopsy Not done

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 J. Whelan M.D. (M. D. or other) _____

Address Charles Bealy Date signed -31-4

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.....

W Van Matre

Licensed Embalmer No. *2825*

P. O. Address.....

4340 Lafayette

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.