DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 21 1942 306

Registration District No. 760 B

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31203

Primary Registration District No. 6001-6048

Registrar's No. 179

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD.

1. PLACE OF DEATH:

(a) County: St Charles

(b) City or town: O Fallon, Mo (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: / (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: None (Specify whether years, months or days)

In this community: Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: St Charles

(c) City or town: (If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? (Yes or No) No

If yes, name country

3. (a) PRINT FULL NAME: Cathrina Schneider

3. (b) If veteran, name war:

3. (c) Social Security No.: None

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Aug (Month) 8 (Day) 1862 (Year)

8. AGE: Years 80 Months Days 20 If less than one day hr. min.

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

10. Usual occupation: House work

11. Industry or business:

FATHER 12. Name: Dont Know

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

MOTHER 14. Maiden name: Anna Margaret

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

16. (a) Informant: Gaton Schneider

(b) Address: O Fallon, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 31, 1942 (Month) (Day) (Year)

(c) Place: burial or cremation: Weldon Spring

18. (a) Signature of funeral director: Morris Mueller

(b) Address: Wentzville Mo

19. (a) Sep 1 -42 (Date received local registrar) (b) E. A. Kirkley (Registrar's signature)

682 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 29 day year 1942 hour 10 minute A. M.

21. I hereby certify that I attended the deceased from July 1940 to Aug 29 1942 that I last saw he alive on Aug 29 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocarditis	4 yrs.
Due to: Pulmonary Edema	48 hrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: P 3d
Of autopsy:

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

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Nicholas J. Hoerch (M. D. or Coroner)

Address: O Fallon, Mo Date signed: 9/1/42

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 Morris Buechang

Licensed Embalmer No. 2146

P. O. Address Wentzville Mo

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

If this body is not embalmed, fact should be so stated above.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31203

Registration District No. 160 B Primary Registration District No. 6001 Registrar's No. 179

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

1. PLACE OF DEATH:

(a) County: St Charles

(b) City or town: O'Fallon
(If outside city or town limits, write "RURAL" and name of township)

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

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

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: St Charles

(c) City or town: St Charles
(If outside city or town limits, write "RURAL")

(d) Street No.: Route #2
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Catherina Schneider

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive: Years

7. Birth date of deceased: Aug (Month) 8 (Day) 1862 (Year)

8. AGE: Years 80 Months Days If less than one day min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 9 Year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (c) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY