DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 30 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35821

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2407

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town ~~Rural O Ferdinand Township~~ Robertson
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution two years and 5 months (Specify whether

In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 7
(If outside city or town limits write "RURAL")

(d) Street No. 4211a Easton
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 33 1 years.

3. (a) PRINT FULL NAME Hyman Schneider

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Ethel Schneider

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

7. Birth date of deceased (unk) (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
ab.	75			hr. min.

9. Birthplace Shimsk Volhynia (City, town, or county) Russia 6 (State or foreign country)

10. Usual occupation Tailor

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name "
15. Birthplace " (City, town, or county) 4 (State or foreign country)

16. (a) Informant Jewish Sanatorium
(b) Address Robertson, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10/28/43 (Month) (Day) (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director Berger Memorial
(b) Address 4715 McPherson

19. (a) OCT 28 1943 (Date received local registrar) (b) E. G. McGavran, M. D. (Registrar's signature) F. S.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day twenty seven year 1943 hour nine minute 30 A M.

21. I hereby certify that I attended the deceased from May 27, 1941, to October 27, 1943; that I last saw him alive on October 27, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	2 day
Due to	
Due to	
Other conditions Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	some years

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)
(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 Selig Simon (M. D. or other)
Address JEWISH SANATORIUM Date signed 10/27/43

(Licensed Embalmer's Statement on Reverse Side)

ROBERTSON, MO.

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.....

Licensed Embalmer No. 1597

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.

No. 2B
—5-43
P I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 2409

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Robertson (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: [illegible]
(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 ..... (b) County .....
(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)
If yes, name country .....

3. (a) PRINT FULL NAME Hymen Schneider
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex M
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 unk (Month) (Day) (Year)
8. AGE: Years ab. 75 Months Days If less than one day ..... hr. ..... min.
9. Birthplace ..... (City, town, or county) Russia (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 ..... day ..... year ..... hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... ; that I last saw him alive on ..... 19..... ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia (Bronchial)	2 day
Due to	
Due to	
Other conditions Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy 9 3d

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 [illegible] (M. D. or other) .....
Address [illegible] Date signed .....

SUPPLEMENTARY

35821