

FILED JUN 24 1944

Primary Registration District No. 6076

Registrar's No. 1308

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town Baden Station  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Halls Ferry Memorial Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 0  
(Specify whether)  
 In this community 0  
years, months or days

3. (a) PRINT FULL NAME Joseph H. Schneider

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widow  
 6. (b) Name of husband or wife Ida Eichner 6. (c) Age of husband or wife if alive dead years  
 7. Birth date of deceased March 30th 1873  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>2</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Unknown  
 13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Harry Schneider-son

(b) Address 2517 No. 10th St.

17. (a) burial (b) Date thereof 6/16/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (c) Signature of funeral director Sullivan Brothers,

(b) Address 2849 North Euclid Avenue

19. (a) JUN 17 1944 (b) E. J. McLauren, M.D.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
 (c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2617 N. 10th  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14th  
 year 1944 hour 1:20 minutes AA M.

21. I hereby certify that I attended the deceased from April  
6, 1944 to April 14, 1944  
 that I last saw him alive on April 14, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary atherosclerosis of arteries  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to 46d

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) NO

(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 E. J. McLauren (M. D. or other) \_\_\_\_\_

Address 7932 Maryland Date signed 6-15-44

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

Dr Neller Harris  
4932 Maryland  
E. Penn.

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.....

working under my personal supervision.

Registered Apprentice No.

Signed

Licensed Embalmer No.

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, fact should be so stated above.