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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **735**
Registrar's No. **793**

Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Isolation Hospital.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **11/18/44 to 1/24/45** to
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME **Leola Schneider.**

3. (b) If veteran, name war _____
 3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced: **Widow**
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: **May 5, 1870**
(Month) (Day) (Year)

8. AGE: Years **74** Months **8** Days **19** hr. _____ min. _____
If less than one day

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

10. Usual occupation: **None**

11. Industry or business _____
 12. Name **Joseph McHose**
 13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
 14. Maiden name **Sophia** **Unknown**
 15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Stella Grady.**
 (b) Address **5600 Arsenal St.**

17. (a) **Burial** (b) Date thereof: **1/26/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director: **Stroot - Carroll**
 (b) Address **4600 Natural Bridge Ave**

19. (a) **JAN 24 1945** (Date received local registrar)
J. F. Bredbeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri.** (b) County _____
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **5800 Arsenal St.**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January,** day **24th**
 year **1945** hour **2** minute **30** A. M.
 21. I hereby certify that I attended the deceased from **11/18 1944** to **1/24 1945**
 that I last saw her alive on **1/24 1945**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Degenerative heart disease**
 Duration _____

Due to _____
 Due to _____
 Other conditions: **atrophic arthritis; deaf-mutism**
(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)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)
 (c) Means of injury _____

23. Signature **P. Maxwell** (M. D. or other) _____
 Address **5600 Arsenal** Date signed **1-24-45**

253

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address *4600 Natural B*

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.