

MISSOURI DIVISION OF HEALTH  
**STANDARD CERTIFICATE OF DEATH**

State File No. **21319**  
 Registrar's No. **5530**

Registration District No. **318**

Primary Registration District No. **1003**

**1. PLACE OF DEATH:**

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Louis City Hospital - Max C. Starkloff  
 (If not in hospital or institution, write street number or location) *Memo*  
 (d) Length of stay: In hospital or institution 8 days  
 In this community Lifetime  
 years, months or days (Specify whether)

**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") 17  
 (d) Street No. 5050 Wren Ave  
 (If rural, give location) 9  
 (e) Citizen of foreign country? NO (Yes or No) 0  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JOHN SCHNEIDER

3. (b) If veteran, name war None  
 3. (c) Social Security No. 487-22-9726

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Helen Schneider  
 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased January 27 1898  
 (Month) (Day) (Year)

8. AGE: Years 50 Months 4 Days 20  
 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Assembler

11. Industry or business Nelson Mfg. CO.

12. Name William Schneider

13. Birthplace St. Louis MO.  
 (City, town, or county) (State or foreign country)

14. Maiden name Mamie DeVonne

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

16. (a) Informant Helen Schneider

(b) Address 5050 Wren Ave.

17. (a) Burial (b) Date thereof 6/19/48  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Laurel Hill Gardens

18. (a) Signature of funeral director Suedmeyer & Son's

(b) Address 3934 N. 20 Street

19. (a) JUN 18 1948 (b) J. F. Bredbeck  
 (Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 17th  
 year 1948 hour 9 minute 505A M.

21. I hereby certify that I attended the deceased from 6/9/48  
 to June 17th 1948  
 that I last saw him alive on June 17th 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction  
reperfusion

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

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

Other conditions because of  
 (Include pregnancy within 3 months of death)  
live; diabetes mellitus.

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? J. F. Bredbeck (Specify type of place) (b) Means of injury 0

23. Signature J. F. Bredbeck 1515 Lafayette 6/17/48 (Other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

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**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 Neville D. Prohaska

Licensed Embalmer No. 3626

P. O. Address 3934 N. 20th ST.

**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.**