

FILED JUL 5 1949 THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **21640**  
**5300**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **HOMER G. PHILLIPS HOSPITAL** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Madison</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>2</b> township)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>17</b> township)	
c. LENGTH OF STAY (In this place) <b>38</b> years		d. STREET ADDRESS (If rural, give location) <b>1802 So. Broadway</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Enroute to City Hosp. #1.</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>ESTHER</b> b. (Middle) <b>MAE</b> c. (Last) <b>SCHNEIDER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>June 17 1949</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>Feb. 19-1908</b>	9. AGE (In years last birthday) <b>41</b>	10. CITIZENSHIP (If other than U.S. citizen, give country) <b>3</b> Months <b>28</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Perryville, Missouri</b> <b>0</b>	

13a. FATHER'S NAME <b>August Ponder</b>	13b. MOTHER'S MAIDEN NAME <b>Myrtle Martin</b>	14. NAME OF HUSBAND OR WIFE <b>Henry</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Henry Schneider Jr.</b>	ADDRESS <b>1802 So. Broadway</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>		<b>1 hr</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Essential hypertension</b> DUE TO (c) _____		<b>2 yrs</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>102.</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>44-4X</b>

22. I hereby certify that I attended the deceased from **May 12, 1949**, to **June 12, 1949**, that I last saw the deceased alive on **June 12, 1949**, and that death occurred at **11 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>J. Schneider</b>	(Degree or title) <b>MD</b>	23b. ADDRESS <b>2026 4093</b>	23c. DATE SIGNED <b>6/28/49</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6-20-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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DATE REC'D BY LOCAL REG <b>6-20-49</b>	REGISTRAR'S SIGNATURE <b>J. Brasola</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Allen McLaughlin</b>	ADDRESS <b>231 N. Fayette</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*How  
ever*

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *O W Cooper*

Licensed Embalmer No. *3830*

P. O. Address *2301 Lafayette*

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

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