No. 300
10.48

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

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32598

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 4013

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN ~~St. Louis~~ Kennedy 19 yrs
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6721 MATHEW ST

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI
b. COUNTY St. Louis
c. CITY OR TOWN ~~ST. LOUIS~~ Kennedy
d. STREET ADDRESS (If rural, give location) 6721 MATHEW, ST.

3. NAME OF DECEASED (Type or Print) a. (First) CHRISTINE b. (Middle) ANNA c. (Last) SCHNEIDEWIND

4. DATE OF DEATH (Month) (Day) (Year) SEPT - 27 - 1949

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH SEPT. 29 1857
9. AGE (In years last birthday) 91 Months 11 Days 28 If under 1 day: Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) ST. CLAIRE CO. ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME NICHOLAS HERERER
13b. MOTHER'S MAIDEN NAME KATHERING WAGNER
14. NAME OF HUSBAND OR WIFE FREDERICH SCHNEIDEWIND
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT'S SIGNATURE OR NAME ADDRESS MISS MARGARET A. SCHNEIDEWIND

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Paralytic Ileus

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

570.1

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 570.1
20. AUTOPSY? YES ☐ NO ☒

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to September 26, 1949, that I last saw the deceased alive on Sept. 25, 1949, and that death occurred at 7:45 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title) [illegible]
23b. ADDRESS 4901 Eastern Ave.
23c. DATE SIGNED 9/27/49

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE SEPT 30 1949
24c. NAME OF CEMETERY OR CREMATORY MARISSA CEMETERY
24d. LOCATION (City, town, or county) MARISSA, ILLINOIS (State)

DATE REC'D BY LOCAL REG. 9-28-49
REGISTRAR'S SIGNATURE Lucent P. Hamb[illegible]
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Parker Undertaking Co. Waterloo Mo.
(Licensed Embalmer's Statement on Reverse Side) C. C. Aldrich Sept Secy

Dr. Sonia Rosell PL-15
Euclid Ey Easton Ave.
Forest 3921

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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Webster Groves M

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.