

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18512**
Registrar's No. **4050**

FILED MAY 19 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.	c. LENGTH OF STAY (in this place) 60	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION Marion Hospital		d. STREET ADDRESS (If rural, give location) 24 1942 a Withnell	

3. NAME OF DECEASED (Type or Print) Magdalena		a. (First)	b. (Middle)	c. (Last) Schneider	4. DATE OF DEATH (Month) (Day) (Year) April 29 1952		
--	--	------------	-------------	-------------------------------	--	--	--

5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH Aug. 21, 1864	9. AGE (In years last birthday) 87	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR 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) Germany		12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	---	--	--

13a. FATHER'S NAME John Wagner		13b. MOTHER'S MAIDEN NAME ?		14. NAME OF HUSBAND OR WIFE John Schneider	
--	--	---------------------------------------	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Mr. & Mrs. Emmett Burgher & Mrs. Ithoff		ADDRESS 4045 Miami
--	-------------------------------------	---	--	------------------------------

18. CAUSE OF DEATH Enter only one cause per line for (b), (c) and (d) <i>Anterior chest wall fracture</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Anterior chest wall fracture</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>
* This term may mean the mode of dying such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>Fracture of femur</i>			5 wk
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 SSO		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
------------------------	--	--	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo
---	---	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Apr 1 1952 m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? fell from 69040
---	---	--

22. I hereby certify that I attended the deceased from **1919**, to **April 1, 1952**, that I last saw the deceased alive on **Apr 20**, 1952, and that death occurred at **5 Am.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Dr. Hester MD</i>	23b. ADDRESS 5600 S Compton	23c. DATE SIGNED 5/29/52
--	---------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE May 1, 1952	24c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	24d. LOCATION (City, town, or county) (State) 1800 Lemay Ferry Rd. St. Louis County, Mo.
---	---------------------------------	---	--

DATE REC'D BY LOCAL REG. APR 30 1952	REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>	25. FUNERAL DIRECTOR'S SIGNATURE BEIDERWIEDEN F.H. INC.	ADDRESS 1936 St. Louis Ave.
--	---	---	---------------------------------------

Dr. Gerard A. Nestor
5600 S. Compton

Phone - SW 3383

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.

Student Embalmer No.

Signed

Max L. Warfel

Signed.....

Student Embalmer

Licensed Embalmer No. 4170

P. O. Address 1936 St Louis Ave

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.