

FILED APR 27 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15363

BIRTH NO. _____		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3058		Registrar's No. 99	
1. PLACE OF DEATH a. COUNTY St. Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY St. Charles			
b. CITY OR TOWN St. Charles		c. LENGTH OF STAY (If in this place) 17 yrs		c. CITY OR TOWN St. Charles		8923	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. JOSEPH HOSPITAL				d. STREET ADDRESS (If rural, give location) 2118 No. Third			
3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Louis c. (Last) Schneider			4. DATE OF DEATH (Month) (Day) (Year) April 21, 1953				
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH 5-23-1867	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months 10 Days 29	IF UNDER 2 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) St. Peters, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Joseph Schneider		13b. MOTHER'S MAIDEN NAME Bushman		14. NAME OF HUSBAND OR WIFE Mary Schneider			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charlotte Auchly, RRI, St. Charles, Mo.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken compensation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis DUE TO (c) Gen. Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 yrs 20 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		4221	
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			
22. I hereby certify that I attended the deceased from March , 1953, to April 21 , 1953, that I last saw the deceased alive on April , 1953 and that death occurred at 7 a. m., from the causes and on the date stated above.							
23a. SIGNATURE A.P. Esch Schmitt, M.D. (Degree or title)				23b. ADDRESS St. Charles Mo.		23c. DATE SIGNED ap. 22/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-23-1953		24c. NAME OF CEMETERY OR CREMATORY All Saints		24d. LOCATION (City, town, or county) (State) St. Peters, Mo.	
DATE REC'D BY LOCAL REG. April 22 1953		REGISTRAR'S SIGNATURE Frankie Hamilton		FUNERAL DIRECTOR'S SIGNATURE Geo. Steyger		ADDRESS St. Peters Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 1 1922

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 E. A. Keithley

Licensed Embalmer No. 1822

P. O. Address Fallon Mo.

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.