

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3252**
Registrar's No. **0360**

FILED FEB 2 1954

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3909 Iowa Ave.		d. STREET ADDRESS (If rural, give location) 24 3909 Iowa Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Alice b. (Middle) M. c. (Last) Schneider		4. DATE OF DEATH (Month) (Day) (Year) January 10, 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH August 26, 1893
9. AGE (In years, last birthday) 60		10. MONTHS 4	11. DAYS 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Thomas Leahy	
13b. MOTHER'S MAIDEN NAME Bertha Birchenbach		14. NAME OF HUSBAND OR WIFE August T. 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. 499-28-8286	
17. INFORMANT'S SIGNATURE OR NAME August T. Schneider		ADDRESS 3909 Iowa Ave.	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) 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"/>		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4201		22. I hereby certify that I attended the deceased from Dec 6, 1954 , to Jan 10, 1954 , that I last saw the deceased alive on Jan 10, 1954 , and that death occurred at 11:55P m., from the causes and on the date stated above.	
23a. SIGNATURE C.E. Koeller M.D. (Degree or title)		23b. ADDRESS 3537 S. Jefferson	
23c. DATE SIGNED Jan 12/54		24a. BURLIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 1/14/54		24c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons	
25. ADDRESS 2630 Gravois Ave.		DATE REC'D BY LOCAL REG. JAN 13 1954	
REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. ADDRESS 2630 Gravois Ave.	

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

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 Robert F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois 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.