

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11036

Health,
Welfare
Public
Service

XC 2848693
SL 7891

FILED MAR 18 1957

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

1914

Registrar's No.

300
1-56

All
diseases
will be listed.

No symptoms
will be listed.

Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

VA Hospital 35 hours
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital		Length of stay in lb 35 Hours	d. STREET ADDRESS 3022 Miami (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Casper Schneider			4. DATE OF DEATH 2-23-57
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) roofer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13. FATHER'S NAME Jacob Schneider		14. MOTHER'S MAIDEN NAME Susan Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 492059148	17. INFORMANT Address VA Hospital Records, St. Louis, Mo.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE SIGMOID COLON WITH GENERALIZED METASTASIS. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) 153X			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. VA attended the deceased from 2-22-57 to 2-23-57 and last saw him alive on 2-23-57 Death occurred at 9:36 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. Gary Bivings M.D.		22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 2-24-57
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE FEB. 26 1957	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.	23d. LOCATION (City, town, or county) ST. LOUIS (State)
24. FUNERAL DIRECTOR ADDRESS Thomas Kates 2906 Gravois		25. DATE RECD. BY LOCAL REG. FEB 25 '57	26. REGISTRAR'S SIGNATURE [Signature]

(Licensed Embalmer's Statement on Reverse Side)

