

Health, Welfare
Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007959
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 530

FILED MAR 21 1959

300
-57

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. JOHNS</u> | | c. CITY OR TOWN <u>ST. JOHNS</u> <u>4201</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2847 ENDICOTT</u> | | d. STREET ADDRESS (If outside, give location) <u>2847 ENDICOTT</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Length of stay in 1b <u>YRS</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | | |
|--|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>OPHELIA</u> Last <u>SCHNEIDER</u> | | | 4. DATE OF DEATH Month <u>FEB</u> Day <u>24</u> Year <u>1959</u> | | |
|--|--|--|---|--|--|

| | | | | | | |
|----------------------|-------------------------------|---|---|---|--|--|
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JUNE 17 1879</u> | 9. AGE (In years last birthday) <u>79 yr</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
|----------------------|-------------------------------|---|---|---|--|--|

| | | | |
|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and state or country) <u>PRAIRIE ROUGE ILL</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
|---|--|--|--|

| | | |
|--|---|---|
| 13a. FATHER'S NAME <u>VITAL LOUVIER</u> | 13b. MOTHER'S MAIDEN NAME <u>MARIA LA ROSE</u> | 14. NAME OF HUSBAND OR WIFE <u>CHARLES SCHNEIDER</u> |
|--|---|---|

| | | | |
|---|--|------------------------------------|---------------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>NONE</u> | 17. INFORMANT <u>DR. WITLER</u> | Address <u>6820 PAGE AVE</u> |
|---|--|------------------------------------|---------------------------------|

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Renal Failure.</u> | DUE TO (c) _____ | |
| | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331x</u> | |

| | |
|---|---|
| 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 _____ a.m. _____ p.m. | 20d. INJURY OCCURRED WHILE AT <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. I attended the deceased from <u>2-23-59</u> , to <u>2-24-59</u> and last saw her alive on <u>2-24-59</u> Death occurred at <u>10:45 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated. |
|--|

| | | |
|--|----------------------------------|------------------------------------|
| 22a. SIGNATURE <u>Dr. Michael Witler MD</u> (Degree or title) | 22b. ADDRESS <u>6820 Page</u> | 22c. DATE SIGNED <u>2-25-59</u> |
|--|----------------------------------|------------------------------------|

| | | | |
|---|---------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 23b. DATE <u>FEB 27 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>NEW PICKER CEMETERY</u> | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MISSOURI</u> |
|---|---------------------------------|--|--|

| | | | |
|---|------------------|--|---|
| 24. FUNERAL DIRECTOR <u>BLIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE</u> | ADDRESS _____ | 25. DATE RECD. BY LOCAL REG. <u>2-25-59</u> | 26. REGISTRAR'S SIGNATURE <u>Jahn E. Murphy M.D.</u> |
|---|------------------|--|---|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *Homer W. Ditz*

Licensed Embalmer No. *3882*
P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.