

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 7 1960

-60-025240

DED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1859 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Clayton</b>		Length of stay in 1b <b>5 Days</b>	c. CITY OR TOWN <b>Lemay</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis County Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>841 Tennessee ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>GEBHARDT</b> Middle <b>SCHNEIDER</b> Last			4. DATE OF DEATH Month <b>6</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-1890</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Marker-- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stupp Brs. Iron Works</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Co. Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
13a. FATHER'S NAME <b>Gebgardt Schneider</b>		13b. MOTHER'S MAIDEN NAME <b>Amelia Ludwig</b>		14. NAME OF HUSBAND OR WIFE <b>Anna</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>488-03-852</b>		17. INFORMANT Address <b>Mrs. Anna Schneider 841 Tennessee ave.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Biateral Diffuse Bronchopneumonia**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) \_\_\_\_\_ DUE TO (c) \_\_\_\_\_

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**Carcinoma of Prostate**

PART III. If deceased was female was there a pregnancy in last 90 days.  
 Yes  N.  Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ 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. I attended the deceased from **6-11-1960** to **6-15-1960** and last saw him alive on **6-15-1960**  
Death occurred at **8:07 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>[Signature]</b>	22b. ADDRESS <b>601 S. Brentwood Blvd.</b>	22c. DATE SIGNED <b>6/14/60</b>
23a. BURIAL / CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 18, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Mausoleum</b>
23d. LOCATION (City, town, or county) (State) <b>1215 Lemay Ferry Rd. Lemay, Mo.</b>		

24. FUNERAL DIRECTOR ADDRESS <b>Hollmeister Mortuaries 7814 S. Broadway</b>	25. DATE RECD. BY LOCAL REG. <b>6-17-60</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
--	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John S. Dennis*

Licensed Embalmer No. 419

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.