

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-026415

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 183

FILED AUG 2 1961

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Charles		Length of stay in 1b 3 weeks	c. CITY OR TOWN St. Charles Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1633 Trendly Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Adam Middle Last Schneider			4. DATE OF DEATH Month July Day 24 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/20/1877	9. AGE (last birthday) 83	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) Builder of Railroad Cars A.C.F. Indt.		10b. KIND OF BUSINESS OR INDUSTRY Germany	11. BIRTHPLACE (City and state or country) U.S.A.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Philip Schneider		13b. MOTHER'S MAIDEN NAME Magdalene Orb		14. NAME OF HUSBAND OR WIFE Katharine Schneider	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Henry Schneider St. Charles, Mo. Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis			INTERVAL BETWEEN ONSET AND DEATH 3 wks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis			Unknown
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 a.m. p.m.	Month, Day, Year	

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 St. Charles, Mo	COUNTY St. Charles	STATE Missouri
21. I attended the deceased from July 3, 1961 to July 23, 1961 and last saw him alive on July 23, 1961 Death occurred at 4:30 1/7 m on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE Eugene J. Canty M.D. (Degree or title)	22b. ADDRESS St. Charles, Mo	22c. DATE SIGNED July 25, 1961	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE July 26, 1961	23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	23d. LOCATION (City, town, or county) St. Charles, Missouri (State)

24. FUNERAL DIRECTOR Arthur C. Baue, St. Charles, Mo.	25. DATE RECD. BY LOCAL REG. July 26-61	26. REGISTRAR'S SIGNATURE Marcella Wilson
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AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John C. Smith

Licensed Embalmer No. 5145

P. O. Address St. Charles, Mo.

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.