

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-039672

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317  
 FILED OCT 26 1961

Primary Registration District No. 500

Registrar's No. 2776

STATE FILE NUMBER

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															
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy, Mo.</u>		Length of stay in 1b <u>8 Days</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>													
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Normandy Osteopathic Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4957 Beacon Avenue,</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle Last <u>SCHNEIDER</u>				4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1961</u>															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-27-1877</u>		9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Forman Broderick-Bascom Rope Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>St. Louis, Mo.</u>		11. BIRTHPLACE (City and state or country) <u>U.S.A.,</u>		12. CITIZEN OF WHAT COUNTRY											
13a. FATHER'S NAME <u>Fred Schneider</u>				13b. MOTHER'S MAIDEN NAME <u>Caroline</u>				14. NAME OF HUSBAND OR WIFE <u>Mrs Dina 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>						17. INFORMANT Address <u>Mrs Dina Schneider, 4957 Beacon Ave.,</u>													
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized toxemia</u> DUE TO (b) <u>Intestinal obstruction</u> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>									
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		COUNTY		STATE	
21. I attended the deceased from <u>12-5-56</u> , to <u>10-1-61</u> and last saw him alive on <u>9-30-61</u> Death occurred at <u>6:20 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.																			
22a. SIGNATURE (Degree or title) <u>Sturknapp Do</u>						22b. ADDRESS <u>4991 Thrush</u>						22c. DATE SIGNED <u>10/2/61</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-4-1961,</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemetery,</u>				23d. LOCATION (City, town, or county) <u>St. Louis,</u>		(State) <u>Missouri.</u>									
24. FUNERAL DIRECTOR <u>Math. Hermann &amp; Son Inc. 2161 E. Fair Ave.,</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10-2-61</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>											

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 Clement M. May

Licensed Embalmer No. 3732

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.