

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

10499

-61-042869

STATE FILE NUMBER

Registration District No.

Primary Registration District No.

Registrar's No.

AMENDED

NOV 28 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis Little Rock Hospital, Inc		d. STREET ADDRESS (If outside, give location) 5817 Saloma	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last George Karl Schnider (Schnieder)			4. DATE OF DEATH Month Day Year November 10 1961		
--	--	--	--	--	--

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-4-1898	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
----------------	---------------------------	---	------------------------------	------------------------------	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spec Ass't Personnel	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) St. Louis, M ^o .	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	---	---	---------------------------------------

13a. FATHER'S NAME George D. Schnider	13b. MOTHER'S MAIDEN NAME Pauline Pieper	14. NAME OF HUSBAND OR WIFE Audrey Schnieder
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W. #1	17. INFORMANT Mrs. Audrey Schnider 5817 Saloma Avenue.
---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure since Sept 20 1961		INTERVAL BETWEEN ONSET AND DEATH 1959
DUE TO (b) Arteriosclerotic Heart Disease		
DUE TO (c) 420.0		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) Pulmonary Infarct, rt.	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 9-25-61 to 11-10-61 and last saw her/him alive on 11-10-61
Death occurred at 10:20 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Claud E. Stasto M.D.	22b. ADDRESS 1755 S Grand	22c. DATE SIGNED 11/11/61
--	------------------------------	------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/13/61	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
--	-----------------------	---	--

24. FUNERAL DIRECTOR John Stygar & Son	ADDRESS 5541 Riverview Blvd.	25. DATE RECD. BY LOCAL REG. NOV 13 1961	26. REGISTRAR'S SIGNATURE Clay Smith, M.D.
---	---------------------------------	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1961 9 23 SA

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

J. W. Rister

Licensed Embalmer No.

3980

P. O. Address

St Louis 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.