

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=61-043971**

STATE FILE NUMBER

AMENDED

**FILED DEC 18 1961**

Registration District No. 3013 Registrar's No. 222

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>CLAY</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>CLAY</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>NORTH KANSAS CITY</b>		Length of stay in 1b <b>30 YRS.</b>	c. CITY OR TOWN <b>NORTH KANSAS CITY</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>821 E. 21 ST. AVE.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>821 E. 21 ST. AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>OTTO</b> Middle <b>U.</b> Last <b>SCHNEIDER</b>			4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>12</b> Year <b>1961</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>6-12-1894</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LARABEE FLR. MILLS</b>		11. BIRTHPLACE (City and state or country) <b>ST. JOSEPH, MO.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13a. FATHER'S NAME <b>FREDERICK SCHNEIDER</b>		
13b. MOTHER'S MAIDEN NAME <b>ANNA HOLSINGER</b>			14. NAME OF HUSBAND OR WIFE <b>BEATRICE SCHNEIDER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES W.W.I.</b>			17. INFORMANT Address <b>MSR. LOUIS SALUZZI 6213 N. OAK ST. K.C.N.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>					<b>year</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) <b>Pulmonary Emphysema</b>				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 <b>Jan 1 1954</b> to <b>12-12-61</b> and last saw him alive on <b>12-12-61</b> Death occurred at <b>11:15</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Robert W. Hodge M.D.</b>			22b. ADDRESS <b>329 Armon W. Hambley Ave</b>		22c. DATE SIGNED <b>12-14-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12-15-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT AUBURN</b>		23d. LOCATION (City, town, or county) (State) <b>ST. JOSEPH MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>D.W. NEWCOMER'S SON NORTH KANSAS CITY</b>		25. DATE RECD. BY LOCAL REG. <b>12-14-61</b>		26. REGISTRAR'S SIGNATURE <b>Marguerite Hudgens</b>	

DR. HODGE  
N.Y.C.

JAN 5 1962

FEB 5 1962

**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 *Glenn H. Hill*  
Licensed Embalmer No. \_\_\_\_\_

Licensed Embalmer No. 4586

P. O. Address K. C. 18, 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.