

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050370

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 4036

FILED JAN 3 1964

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Louis</u>		a. STATE <u>Mo.</u>	b. COUNTY <u>St. Louis</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		c. CITY OR TOWN <u>University City</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>County Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>6633a Clemens</u>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>Joseph</u> Middle <u>Schneider</u> Last <u>Schneider</u>		Month <u>12</u> Day <u>30</u> Year <u>63</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</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>unk.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garm. Manf.</u>	11. BIRTHPLACE (City and state or country) <u>Russia</u>
13a. FATHER'S NAME <u>Unknown Schneider</u>		14. NAME OF HUSBAND OR WIFE <u>Sophie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT Address <u>Sophie Schneider 6633a Clemens</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u>			
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 COUNTY STATE	
21. I attended the deceased from <u>12-29-63</u> to <u>12-30-63</u> and last saw her/him alive on <u>12-30-63</u> . Death occurred at <u>10:55</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>John M. Jansen, M.D.</u>		22b. ADDRESS <u>60150 Brentwood Clayton Mo.</u>	
22c. DATE SIGNED <u>12-30-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.</u>	23b. DATE <u>12/31/1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>	
23d. LOCATION (City, town, county) (State) <u>University City, Mo.</u>			
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 M</u> ADDRESS <u>cPherson</u>		25. DATE RECD. BY LOCAL REG. <u>12-30-63</u>	
		26. REGISTRAR'S SIGNATURE <u>John M. Murphy, M.D.</u>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

1 4002

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9331X

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13

STATEMENT BY LICENSED EMBALMER

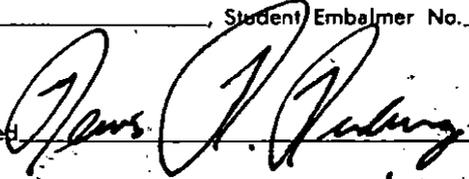
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 8429

P. O. Address _____

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.