

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

34643

1. PLACE OF DEATH

County St. Louis Registration District No. 1123
Township CARONDELET Primary Registration District No. 6248 A
City (No. 210 Ave. H.) St. _____ Ward _____

File No. _____
Registered No. 413
St. _____ Ward _____

2. FULL NAME

Joseph Schneider's
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (if nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widowed
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF Joseph Schneider's
(or) WIFE OF Louisa Schneider's

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 17 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
84 7 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gardner
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Wm Schneider

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT Joseph A. Schneider
(Address) 210 Ave H

15. FILED Nov. 23 19 27 L. C. Obrock
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 20 19 27

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1927, to Nov 20 1927
that I last saw h. _____ alive on Nov 19 1927, and that death occurred, on the date stated above, at 3:50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

15 15 15
Dilatation of Heart
Gall Stone Colic
CONTRIBUTORY (Cholelithiasis)
(SECONDARY) (duration) 1 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) A. W. Oster M. D.
Nov 21 1927 (Address) 601 Missouri Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Louis **DATE OF BURIAL** Nov 24 19 27

20. UNDERTAKER Hendrick & Co **ADDRESS** 7819 N. 4th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

