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

Do not use this space.

11588

**1. PLACE OF DEATH**

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City ..... (No. St. Marys Infirmary St. ..... Ward)

File No. .....

Registered No. 3434

**2. FULL NAME** Mary Sophia Schneider

(a) Residence. No. 3804 Cleveland Ave. St. 17 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: Femal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Phillip Schneider

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 17-1890

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| 38 | 2 | 7 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Lancing
(STATE OR COUNTRY) Mich

PARENTS

10. NAME OF FATHER Elsworth Knickobocker
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) New York
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Phillip Schneider
(Address) 3804 Cleveland Ave

15. FILED MAR 27 1928, 19 Max C Starkey REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/24 1928

17. I HEREBY CERTIFY, That I attended deceased from 3/19/28, 19 ..... to 3/24/28, 19 ..... that I last saw her alive on ~~[illegible]~~ 3/24/28, 1928, and that death occurred, on the date stated above, at ~~3/24/28~~ 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia. — bilateral.
108
1014
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Earl Smith, M. D
3/25, 1928 (Address) St Marys Infirmary.

*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: De Soto Mo
DATE OF BURIAL: 3-26 1928

20. UNDERTAKER: Coxwell + Son
ADDRESS: De Soto Mo.

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.