

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

Do not use this space.

33874

1. PLACE OF DEATH

County Jackson
Township Hart
City K. C. Mo.

Registration District No. 1002
Primary Registration District No. Research Hosp.

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

2. FULL NAME

Hattie Marie Schneider

(a) Residence. No. 1408 Cherry St. 2 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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Fe</u>	4. COLOR OR RACE <u>wh.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Dr. Louis C. Schneider</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>7-28-1885</u>		
7. AGE YEARS <u>44</u>	MONTHS <u>2</u>	DAYS <u>20</u>
If LESS than 1 day, _____ hrs. or _____ min.		

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) _____
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER George W. Hancock

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

12. MAIDEN NAME OF MOTHER Mary Watson

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

14. INFORMANT Dr. Louis Schneider
(Address) 1408 Cherry

15. FILED 10-19-1929 M. M. Crowe
REGISTRAR asst.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-18-1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 11, 1929, to Oct 18, 1929 that I last saw h. alive on Oct 18, 1929 and that death occurred, on the date stated above, at 2:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Cardiac dilatation
66A
93B
(duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) Following tetraplegia
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED? IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? yes DATE OF Oct 18-1929
WAS THERE AN AUTOPSY? not permitted; refused
WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Kerwin Ruess M. D.
10/18, 1929 (Address) K 6 Mo

*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 Mt. Moriah DATE OF BURIAL 10-22 1929

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K. C. Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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