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

Do not use this space.

6817

File No. .....
Registered No. 1653

1. PLACE OF DEATH

County ..... Registration District No. 7801
Township ..... Primary Registration District No. .....
City Maryville (No. City Hospital St. ..... Ward)

2. FULL NAME Fred Schneider

(a) Residence. No. 1109a Tyler St., 26 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 7 - 1866

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	5	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Foreman Day
(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Dry Goods
(c) Name of employer Box Co

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

PARENTS

10. NAME OF FATHER Fred Schneider Sr.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Caroline Scheiner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Chas. Schneider
(Address) City Hospital

15. FILED FEB 17 1930 Kate C. Harris REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 14 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1930 to Jan 14 1930 that I last saw him alive on Jan 14 1930 and that death occurred, on the date stated above, at 1 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Arterio Sclerosis
8 D
97 ? (duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (SECONDARY) Hemiplegia (Right) Cause Unknown
(duration) ....yrs. ....mos. 18 ds.

18. WHERE WAS DISEASE CONTRACTED 1109 a Tyler
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Benj Margolin, M. D.
1/14, 1930 (Address) City Hospital

*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	DATE OF BURIAL
Friedens	Feb 17 1930
20. UNDERTAKER	**ADDRESS**
Math Hermann & Son	2161 a Park Ave

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.

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

Schneider