

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

Do not use this space

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City St. Louis, Mo. (No. 5411) S. Broadway St. _____ Ward _____

File No. 28021
 Registered No. 7850

2. FULL NAME Joseph P. Schneider.
 (a) Residence. No. 5411 S. Broadway. St. 15 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 Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married.
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 22, 1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
55 11 13

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis,
 (STATE OR COUNTRY) Missouri.

10. NAME OF FATHER Philip Schneider.

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

12. MAIDEN NAME OF MOTHER Blandina Schuren

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

14. INFORMANT Mary Schneider
 (Address) 5411 S. Broadway

15. FILED Aug - 6 1930 [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 4, 1930.
17. I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1929 to Aug. 4, 1930, 1929 to Aug. 4, 1930, and that I last saw him alive on Aug. 4, 1930, and that death occurred, on the date stated above, at 11:00 p. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Pulmonary Tuberculosis
33A (duration) 1 do not know yrs. mos. da.

CONTRIBUTORY (SECONDARY) None
 (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH. I do not know

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Sputum
 (Signed) Caroline Schlenker, M. D.
8/6, 1930 (Address) 3606 Gravois Av.

*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. Olive Cemetery **DATE OF BURIAL** Aug. 7, 1930.

20. UNDERTAKER Southern U. & L. Co. **ADDRESS** 6320 S. Grand.

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.

3515th St. N. S. 1001
3600 S. 1001