

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. THIS IS A PERMANENT RECORD

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

Do not use this space.

NOV 2 1935

31335

1. PLACE OF DEATH

County

Registration District No. **791**

Township

Primary Registration District No. **1003**

City **St. Louis,**

(No. **St. Anthonys Hospital**)

File No.

Registered No. **8172**

2. FULL NAME **Lillian Schneider**

(a) Residence, No. **5428 Bates Str.** St. **2** Ward.

Length of residence in city or town where death occurred **27** yrs. **5** mos. **26** ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 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 **Edward Schneider**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Mar. 30, 1908**

AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
27	5	26		

8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc. **Housewife**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

FATHER 13. NAME **Joseph J. Kaspar**

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.**

MOTHER 15. MAIDEN NAME **Willie Martinek**

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Troy Mo.**

17. INFORMANT (ADDRESS) **Edward Schneider 5428 Bates Str**

18. BURIAL, CREMATION, OR REMOVAL **Hawk Point Mo. DATE 9-30-35**

19. UNDERTAKER (ADDRESS) **H. C. Maydell 1626 Alley**

20. FILED **SEP 28 1935** **J. T. Bredeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9/26/35**

22. I HEREBY CERTIFY, That I attended deceased from **9/21/35** to **9/26/35**

I last saw him alive on **9-26-1935**. Death is said to have occurred on the date stated above, at **10:30 p.m.**

The principal cause of death and related causes of importance were as follows:

Pulmonary Embolism
Acute Nephritis
Anginal Cardiac Disease
 Other contributory causes of importance:
Raynaud's (8 months)
Cerebral Operation

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? **Y**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) **J. T. Bredeck** M. D.
 (Address) **345 S. Grand St**

