

OCT 14 1937

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

33121
Do not use this space.

1. PLACE OF DEATH

(a) County 2 Registration District No. **1003**
(b) Township Primary Registration District No.
(c) City **St. Louis, Missouri** (d) Street No. **St. Lukes Hospital** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **9175**

2. PRINT FULL NAME **Aloysius Schniers**

(a) Residence, No. St. **NR** **Germantown, Illinois**
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 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 **Catherine Schniers**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 4th, 1902**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
35 2 25
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Engineer**
9. Industry or business in which work was done, as saw mill, bank, etc. **(Flour Mill)**
10. Date deceased last worked at this occupation (month and year) **September 1937** 11. Total time (years) spent in this occupation **12 Yrs**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germantown, Illinois.**

13. NAME **Herman Schniers Sr.**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germantown, Illinois**

15. MAIDEN NAME **Elizabeth Frerker**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Germantown, Illinois**

17. INFORMANT **Mrs Catherine Schniers** (ADDRESS) **Germantown, Illinois**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Germantown, Illinois** **October 2, 1937**

19. FUNERAL DIRECTOR **Albert H. Hoppe Inc.** (ADDRESS) **429 N. Euclid Avenue**

20. **SEP 30 1937** 19..... **J. Predeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **September 29th, 37**

22. I HEREBY CERTIFY, That I attended deceased from **Sept. 20**, 19**37**, to **Sept. 29**, 19**37**
I last saw him alive on **September 27**, 19**37**. Death is said to have occurred on the date stated above, at **11:00 A.M.**
The principal cause of death and related causes of importance were as follows:

Subacute Sinus Thrombosis (Pt Side) Sepsis Septicemia due to Sinus Thrombosis
Other contributory causes of importance:

Name of operation **826** Date of
What test confirmed diagnosis? Was there an autopsy? **yes**

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 **Stroke** (Signed) **MD Heathley** M.D.
(Address) **MD Heathley**

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.

OCCUPATION FATHER MOTHER 22700

STATEMENT BY LICENSED EMBALMER

I, Guy W. Wilkinson, Licensed Embalmer No. 3575

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Guy W. Wilkinson
Licensed Embalmer No. 3575

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)