

REC'D JUN 21 1939

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

18550
Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 294
 (b) Township Central Primary Registration District No. 4178
 (c) City or Saint Clair (d) Street No. _____ 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

536 Joe Schneider
 (a) Residence, No. _____ St. (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 Lydia Schneider

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 23, 1889

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
49 9 27

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 9. Industry or business in which work was done, as 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) Pacific, 0
 (STATE OR COUNTRY) Mo.

FATHER 13. NAME Henry Schneider 0

14. BIRTHPLACE (CITY OR TOWN) Pacific, 0
 (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Catherine Reed

16. BIRTHPLACE (CITY OR TOWN) Pacific,
 (STATE OR COUNTRY) Mo.

17. INFORMANT Lydia Schneider
 (ADDRESS) St. Clair, Mo.

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Odd Fellows, St. Clair DATE May 22, 1939

19. FUNERAL DIRECTOR (NAME) Casey & Lenox
 (ADDRESS) St. Clair, Mo.

20. FILED 619 1939 W. A. D. [Signature]
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-27- 1939

22. I HEREBY CERTIFY, That I attended deceased from April 1, 1937, to 5-19- 1939
 I last saw him alive on 5-19-1939 Death is said to have occurred on the date stated above, at 4:40 p. m.
 The principal cause of death and related causes of importance were as follows:

Spinal Septicemia ?
 Other contributory causes of importance: 34
Structure of esophagus

Name of operation _____ Date of _____
 What test confirmed diagnosis? Lab Was there an autopsy? No

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 _____ M. D.
 (Signed) W. A. D. [Signature]
 (Address) _____

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.

I X 1603

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *R. M. Leroy*

Licensed Embalmer No. 3601

P. O. Address. Paint Clair, Missouri

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.)

If this body is not embalmed, above space should be left blank.