

REC'D AUG 17 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH25440
Do not use this space.

1. PLACE OF DEATH

(a) County Cole Registration District No. 215
 (b) Township Liberty Primary Registration District No. 5295 Registered No. 1997
 (c) City Toas, Mo. (d) Street No. _____
 (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.

2. PRINT FULL NAME

536 Herman H. Schnieders
 (a) Residence, No. Toas, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) -Anna Wortman Schnieders
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 25, 1854
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 2 2
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Merchant
 9. Industry or business in which work was done, as saw mill, bank, etc. Retired
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) Toas, Mo. (STATE OR COUNTRY) _____
 FATHER 13. NAME Henry Schnieders
 14. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY) _____
 MOTHER 15. MAIDEN NAME Helen Walton
 16. BIRTHPLACE (CITY OR TOWN) Germany (STATE OR COUNTRY) _____
 17. INFORMANT Clarence Schnieders (ADDRESS) Toas, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Toas, Mo. DATE 7/30/39
 19. FUNERAL DIRECTOR (NAME) John F. Heinrichs (ADDRESS) Jefferson City, Mo.
 20. FILED Aug 10 1939 Joseph M. Riedel Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 27, 1939
 22. I HEREBY CERTIFY, That I attended deceased from May 1, 1937, to July 27, 1939
 I last saw him alive on July 27, 1939. Death is said to have occurred on the date stated above, at 12:40 P
 The principal cause of death and related causes of importance were as follows:
Chronic nephritis
with renal edema (uremia)
 Date of onset _____
 Other contributory causes of importance:
Senile dementia
Fracture right humerus
 Name of operation Nephrectomy Date of _____
 What test confirmed diagnosis? Clinical 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? No
 If so, specify _____
 (Signed) John A. Taylor, M. D.
 (Address) Jefferson City, Mo.

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.

1946

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 John J. Hamrick

Licensed Embalmer No. 2655

P. O. Address Jeffersonville

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

25-440
Do not use this space.

1. PLACE OF DEATH

(a) County Cole Registration District No. 215
(b) Township Liberty Primary Registration District No. 5295 Registered No. 7
(c) City _____ (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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Herman H. Schneiders
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-27-1939

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

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

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

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
85 2 2

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

Chronic nephritis Date of onset _____
180 W

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 _____

Other contributory causes of importance:
Senile Dementia Fracture of right humerus

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER 15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide _____ Date of injury July 1, 1939
Where did injury occur? Gas. mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. In home

Manner of injury fell on floor
Nature of injury fracture of right humerus

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Leon A. Taylor, M. D.
(Address) Jefferson City, Mo.

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state

S-25440

(193)