

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.

JAN 12 1940

791
1008

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH: 3
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Edward Taylor Hospital
(If not in hospital or institution, write street number of location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community life years, months or days

3. (a) PRINT FULL NAME Charles Michael Schneider
3. (b) If veteran, name war no 3. (c) Social Security No. 486-16-4281

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Schneider 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased July 6, 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 5 9 _____ hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Contractor

11. Industry or business SAME

MOTHER FATHER { 12. Name John Michael Schneider
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Caroline Klinga
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Harry Schneider
(b) Address 1522 N. 9th St.

17. (a) Burial (b) Date thereof Dec. 18, 39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or _____ New Pickers

18. (a) Signature of informant Joseph Nicholas
(b) Address 1431 Union Blvd.

19. (a) DEC 16 1939 (b) _____
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")
(d) Street No. 1522 N. 9th St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 15
year 1939 hour 5:03 minute a. M.
21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) Means of injury 4
23. Signature Joseph M. Johnson
Address Deputy Coroner Date signed _____

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 *L. M. White*

Licensed Embalmer No. *3973*

P. O. Address.....

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.