S. No. 2
—11-10-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13520

MAY 15 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3722

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis 1
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 35 yrs
years, months or days) 536

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 6

(c) City or town St. Louis
(If outside city or town limits write "RURAL")

(d) Street No. 1394a Montclair Avenue
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 35 years.

3. (a) PRINT FULL NAME REBECCA BESSIE SCHNEIDER

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Simon Schneider

6. (c) Age of husband or wife if alive (unk) years

7. Birth date of deceased ab. 1895 (Month) (Day) (Year)

8. AGE: Years ab. 45 | Months | Days | If less than one day ___ hr. ___ min.

9. Birthplace Volhynia (City, town, or county) Russia (State or foreign country) 7

10. Usual occupation at home 7

11. Industry or business

FATHER
12. Name Max Seidel 7
13. Birthplace (City, town, or county) Russia (State or foreign country)

MOTHER
14. Maiden name Anna (unk)
15. Birthplace (City, town, or county) Russia (State or foreign country)

16. (a) Informant Simon Schneider
(b) Address 1394a Montclair

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 4 (Month) 25 (Day) 40 (Year)
(c) Place: burial or cremation Chesed Shel Emeth

18. (a) Signature of funeral director H. B. Bergerson
(b) Address 4715 McPherson

19. (a) APR 24 1940 (Date received local registrar) J. F. Anderson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
year 1940 hour 9 minute 00 A M.

21. I hereby certify that I attended the deceased from April 15, 1940, to April 23, 1940
that I last saw her alive on April 23, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac decompensation (auricular flutter)	3 days
Due to	
Due to	
Other conditions Bronchopneumonia (Include pregnancy within 3 months of death)	
Major findings: Of operations Intra-ligamentary fibromyoma Uterus non malignant	
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?
8/6/11 (Specify type of place)
While at work? (e) Means of injury

23. Signature O N Anderson (M. D. or other)
Address BARNES HOSPITAL Date signed 4-23-40

(Licensed Embalmer's Statement on Reverse Side)

Berger

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.....

Licensed Embalmer No. 1597

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.