

Registration District No. 548

Primary Registration District No. 4323

Registrar's No. 42

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Palmyra Mo
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 74 years (years, months or days)

3. (a) PRINT FULL NAME Edward G. Schneider
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Adelia Baker
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 23 1866 (Month) (Day) (Year)

8. AGE: Years <u>74</u>	Months <u>-</u>	Days <u>29</u>	If less than one day hr. _____ min. _____
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9. Birthplace Palmyra Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Contractor

11. Industry or business _____

MOTHER FATHER {
12. Name Wm E. Schneider
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Mary Schwartz
15. Birthplace La Grange Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Josephine Hutchison
(b) Address Palmyra Mo.

17. (a) Burial (b) Date thereof 8-24-40 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Palmyra Mo.

18. (a) Signature of funeral director E. J. Sraque
(b) Address Palmyra Mo.

19. (a) Aug 24 1940 (b) Gertrude Lee (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug 21 day _____ year 1940 hour 7 minute _____ M.

21. I hereby certify that I attended the deceased from Aug 1 to Aug 21, 1940, that I last saw him alive on Aug 21, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Payer's pneumonia Duration 3-4 weeks

Due to Heart & Gall bladder complications

Due to not definite

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? U.S.A. (Specify type of place) (e) Means of injury _____

23. Signature Mr. G. H. H. H. (M. D. or other MD.) Address Palmyra Mo Date signed 8-23-40

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.

125A

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.....

Carl Abbott....., Registered Apprentice No. 229

working under my personal supervision.

Signed E. J. Smaque.....

Licensed Embalmer No. 3245

P. O. Address Palmira Me.

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.

2B
21-40
X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **29094**

Registration District No. **548**

Primary Registration District No. **4323**

Registrar's No. **42**

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

1. PLACE OF DEATH:

(a) County **Marion**
(b) City or town **Palmyra**
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Edward J. Schneider**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **m** 5. Color or race **w**
6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive

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

8. AGE: Years Months Days If less than one year
74 - 29 min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **21** year **1940** hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that he or she was h. alive on and that death occurred on the date and hour stated above.

Immediate cause of death
Toxic jaundice
Liver and gall bladder
Complication not definite
Probably carcinoma
Other conditions (Include pregnancy within 3 months of death) **N.M.D.**

Duration

PHYSICIAN

Major findings: Of operations **46**
Of autopsy

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) (e) Means of injury

23. Signature **P. A. ...** (M. D. or other)
Address **Palmyra** Date signed

SUPPLEMENTARY

