

FILED APR 14 1943
Registration District No.

Primary Registration District No. 5667

Registrar's No.

1. PLACE OF DEATH:

(a) County LINCOLN
(b) City or town RURAL (BEDFORD TWP.)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LINCOLN
(c) City or town RURAL (BEDFORD TWP.)
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME JOHN HENRY SCHNEIDER

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife CHRISTINE KATHERINE SIEVERT 6. (c) Age of husband or wife if alive years
7. Birth date of deceased NOV. 8, 1867
(Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days 17 If less than one day hr. min.

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

10. Usual occupation FARMER

11. Industry or business DWN FARM

12. Name GOTTLIEF SCHNEIDER

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

14. Maiden name LOUISE SCHEER

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

16. (a) Informant MISS JOHN H. SCHNEIDER

(b) Address TROY MO

17. (a) BURIAL (b) Date thereof MAR. 28 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation TROY, PEN TROY MO.

18. (a) Signature of funeral director Kemper Funeral Home

(b) Address Troy, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 25
year 1943 hour 2 minute 40 A.M.

21. I hereby certify that I attended the deceased from 19..... to 19.....
that I last saw him alive on MARCH 25, 1943,
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction 1 yr.
Arterio-sclerosis 5 yrs

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 93 & 2

Major findings: Of operations

Of autopsy

Duration

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) (M. D. or other)

23. Signature J. T. Roy (M. D. or other) 0
Address TROY, MO Date signed 4/25/43

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

5-4-17-39 X32873

000

MOTHER FATHER

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.....

Joseph J. Marsh

Licensed Embalmer No. *3932*

P. O. Address... *Boyer, Mo*

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10744

Registration District No. 179

Primary Registration District No. 5667

Registrar's No.

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Rural
(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 _____ (Specify whether)
In this community _____ years, months or days

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Henry Schneider

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

4. Sex M 5. Color of 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 Nov 8
(Month) (Day) (Year)

8. AGE: Years 75 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
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) Mar 30-43 (b) Mrs. Fay Jackson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 21 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

5-10744