

U. S. No. 2  
FORM-2-43  
Rev. 5-17-39  
I X35897

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 27 1944  
Registration District No. 818

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 948  
Registrar's No. 611

Primary Registration District No. 1003

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

1. PLACE OF DEATH:  
(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:  
St. Anthony 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 3 days  
years, months or days

3. (a) PRINT FULL NAME Albert Lee Schneider  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: Sent 25 1935  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
7 3 24 hr. min.

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

10. Usual occupation School-age

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Albert Schneider  
13. Birthplace Clayton Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Willie P. Johnson  
15. Birthplace Muskogee Okla.  
(City, town, or county) (State or foreign country)

16. (a) Informant John Schneider  
(b) Address Clayton-R#1 Box 254

17. (a) Burial (b) Date thereof: 1-21-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New SS Peter-Pauls

18. (a) Signature of funeral director Blumens Boerke  
(b) Address 2504 Woodson Overland Mo

19. (a) JAN 20 1944 J. J. Brudeck  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town Clayton Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Conway Road  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18 day Jan  
year 1944 hour 3:30 minute P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 1944, to January 18, 1944  
that I last saw him alive on January 18, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Toxemia  
Duration 3 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Mechel's diverticula - 3 days  
(Include pregnancy within 3 months of death)

Major findings Of operation Mechel's diverticula  
Of autopsy Mechel's diverticula  
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) No  
(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 case) (c) Means of injury \_\_\_\_\_

23. Signature John Schneider M.D.  
Address 3739 Gravois Date signed Jan 18, 1944

**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 *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *Overland 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.**