V. S. No. 2
0M—5-42
ev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30681

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 96

1. PLACE OF DEATH:
(a) County HOWELL
(b) City or town WEST PLAINS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WEST PLAINS HOSPITAL 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 33 DAYS (Specify whether years, months or days)
In this community 69 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County HOWELL 46
(c) City or town WEST PLAINS (If outside city or town limits, write "RURAL") 1
(d) Street No. 646 ST. LOUIS ST. (If rural, give location) 1
(e) Citizen of foreign country? No. (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME ALEXANDER SCHNEIDER

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex MALE 0

5. Color or race WHITE

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

6. (b) Name of husband or wife JULIA TAYLOR SCHNEIDER

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased NOVEMBER (Month) 13, (Day) 1866 (Year)

8. AGE: Years 78 Months 7 Days 23 If less than one day hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name FRANK SCHNEIDER
13. Birthplace Alsace-Lorraine (City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. JULIA SCHNEIDER
(b) Address WEST PLAINS, Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 8, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation OAK LAWN CEM. WEST PLAINS, Mo.

18. (a) Signature of funeral director Hal Thomburgh
(b) Address WEST PLAINS, Mo.

19. (a) Sept. 14, 1945 (Date received local registrar) (b) Gladys Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 6 year 1945 hour 5 minute 4 A.M.

21. I hereby certify that I attended the deceased from 6/3, 1945 to 7/6, 1945 that I last saw alive on 7-5-, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Septicemia	7 days
Due to Urinary retention	
Due to Hypertrophy prostate	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 1370	PHYSICIAN — Underline the cause to which death should be charged statistically.
Of autopsy	

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) X
(b) Date of occurrence X
(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? X (Specify type of place) (e) Means of injury 0

23. Signature Thomas Thompson (M. D. or other) MD
Address West Plains Mo. Date signed 9/8/45

N 19

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5.
District File Number 10-45-508
Date Filed 10-13-45

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, ~~only~~ .....

..... Registered Apprentice No. .....

working under my personal supervision.

Signed Hal Thornburgh

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.