

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **1104**

Registration District No. **318** Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County **St. Louis, Missouri**
(b) City or town **St. Louis, Missouri**
(c) Name of hospital or institution: **5035 Grace Ave.,**
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(d) Street No. **5035 Grace**
(e) Citizen of foreign country? _____
If yes, name country _____

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **31st**
year **1946** hour **8** minute **15 a.**M.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Elizabeth Schneider**
6. (c) Age of husband or wife if alive **65** years
7. Birth date of deceased **May 1, 1877**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **12/3** 19**45** to **1/30** 19**46**
that I last saw **her** alive on **1/30** and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
68 **8** **30** hr. min.

Immediate cause of death **Cardio Vasculer renal dision**
Due to **acute nephritis ascites**

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

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

10. Usual occupation **Fabrey**

11. Industry or business _____
12. Name **Unknown**
13. Birthplace **Germany**
14. Maiden name **Unknown**
15. Birthplace **Germany**

Major findings: **1/31**
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Elizabeth Schneider**
(b) Address **5035 Grace Ave.,**
17. (a) **Burial** (b) Date thereof **2-4-46**
(c) Place: burial or cremation **New SS Peter & Paul Southern Funeral Home**
18. (a) Signature of funeral director _____
(b) Address **6322 S. Grand Blvd.**
19. (a) **FEB 1 1946** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(e) Means of injury _____
23. Signature **J. J. G... M.D.** (M. D. or other) _____
Address **6520 S. Perry** Date signed **2/1/46**

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

MOTHER FATHER

DR GRANETO
5221 S. BRDY

Lo 1911

163

768

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 J. Wm. Bentley
Licensed Embalmer No. 3653
P. O. Address St. Louis, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Feb*Registration District No. *318*Primary Registration District No. *1003*Registrar's No. *1184*

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:

(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)3. (a) PRINT
FULL NAME*Adam 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..... years

7. Birth date of deceased

May
(Month)*1*
(Day)*1918*
(Year)

8. AGE:

Years

Months

Days

If less than one day

68

.....hr.min.

9. Birthplace

(City, town, or county)

Germany
(State or foreign country)

10. Usual occupation

Stabaren

11. Industry or 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) (Burial, cremation, or removal)

- (b) Date thereof.....

(Month) (Day) (Year)

- (c) Place: burial or cremation.....

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

- (b) Address.....

J. F. Broderick
Registrar's signature

19. (a) (Date received local registrar)

- (b)
- J. F. Broderick*

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... day.....
-
- year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....;

that I last saw him..... alive on....., 19.....;

and that death occurred on the date and hour stated above.

Immediate cause of death.....

Duration

Due to.....

Due to.....

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 sta-
tistically.

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?
 (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other)

Address..... Date signed.....

FEB 21 1946

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

3083

894