

FILED OCT 6 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 30465

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1164

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. 5 days.  
(Specify whether  
In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1013 Powell St.  
(If rural, give location)  
(e) Citizen of foreign country? No  
(Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME Lillian Schneider.

3. (b) If veteran, name war No  
3. (c) Social Security No. None

4. Sex Female  
5. Color or race White  
6. (a) Single, widowed, married, divorced, Single

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

7. Birth date of deceased: February 8 1875  
(Month) (Day) (Year)

8. AGE: Years 71 Months 11 Days 12  
If less than one day hr. min.

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

10. Usual occupation At home

11. Industry or business At home

12. Name Ulrich Schneider

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

14. Maiden name Katherine Schott

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

16. (a) Informant Miss Ada Schneider

(b) Address St. Joseph, Mo.

17. (a) burial (b) Date thereof 1/22/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Walter B. Cole & Bowman

(b) Address St. Joseph, Mo.

19. (a) 10-1-47 (b) G. B. Jenkins  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20  
year 1947 hour 9 minute 30 A. M.

21. I hereby certify that I attended the deceased from July 1946 to Jan. 20 1947  
that I last saw her alive on Jan 20 1947  
and that death occurred on the day and hour stated above.

Immediate cause of death: Fibrosarcoma bronchus 9 mo.

Due to

Due to

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy As above

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 Harold J. Brunner (M. D. or other) Address St. Joseph, Mo. Date signed 9/27/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

7-14-1915 CHARLES

**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 Raymond H. Marchand

Licensed Embalmer No. 4413 A

P. O. Address 319 So 10th St Joseph

**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.**