

FILED MAR 17 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2675

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>6051</u>		Registrar's No. <u>48</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles, rural</u>		c. LENGTH OF STAY (In this place) <u>Life time</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles rural</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. CHARLES RURAL</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>--</u> c. (Last) <u>Schneider Sr.</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 8, 1949</u>				
5. SEX <u>U</u> <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (State) <u>never married</u>	8. DATE OF BIRTH <u>April 3, 1877</u>		9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>5</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>St. Peters, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Anton Schneider</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Iffrig</u>		14. NAME OF HUSBAND OR WIFE <u>Clara Schneider</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Conrad Schneider, RRI St. Charles Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute cardiac failure</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart disease</u>  - DUE TO (c)  11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>  <u>Undet.</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>1450</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/28</u> , 19 <u>48</u> , to <u>3/7</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>March 7</u> , 19 <u>49</u> , and that death occurred at <u>8 AM</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>L.R. McIntire M.D.</u>				23b. ADDRESS <u>St. Charles, Mo.</u>		23c. DATE SIGNED <u>3/9/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Mar. 11, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>All Saints</u>		24d. LOCATION (City, town, or county) (State) <u>St. Peters, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>3-9-49</u>		REGISTRAR'S SIGNATURE <u>Fannie Hamilton</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Geo. Steffater</u>		ADDRESS <u>St. Peters Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
District Health Officer No. 9,  
District No. 9,  
District No. 9,  
Date Filed 3-16-49  
District No. 9

number

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed E. A. Keithly

Licensed Embalmer No. 827

P. O. Address Stallen 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: