

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21641**
Registrar's No. **5829**

FILED JUL 15 1949

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital		d. STREET ADDRESS (If rural, give location) 4474 Kenneth Place	

3. NAME OF DECEASED (Type or Print) a. (First) Henrietta C. b. (Middle) Schneider c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) July 4, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Oct. 27, 1873	9. AGE (In years) (last birthday) 75	IF UNDER 1 YEAR Months 8	IF UNDER 1 YEAR Days 7	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME John Landwehr	13b. MOTHER'S MAIDEN NAME Anna Sievers	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Miss Irene Schneider ADDRESS 4474 Kenneth
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 hrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES DUE TO (b) Fracture of right femur DUE TO (c) Pernicious anaemia		
III. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) St. Louis Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 30 1949	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fall
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22. I hereby certify that I attended the deceased from **June 29, 1949** to **July 4, 1949** that I last saw the deceased alive on **July 4, 1949**, and that death occurred at **3:45 PM** from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. M. Gervais M.D.	23b. ADDRESS 4356 Narne Ave	23c. DATE SIGNED 7/5/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/7/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri Mo
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DATE REC'D BY LOCAL REG. JUL 5 1949	REGISTRAR'S SIGNATURE J. Blaser	25. FUNERAL DIRECTOR'S SIGNATURE Bromschwig and Son ADDRESS W. FLORISSANT AVE
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Eaton R. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.