

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28526
7127
Registrar's No.

BIRTH NO. 99911 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 1828 Lami St.	
3. NAME OF DECEASED (Type or Print) a. (First) GUSTAV b. (Middle) c. (Last) SCHNEIDER			4. DATE OF DEATH (Month) (Day) (Year) August 15th, 1949
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 21, 1868
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Print Shop	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Anna Schneider
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No none		16. SOCIAL SECURITY NO. 491-18-9014	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Anna Schneider 1828 Lami St.
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerotic heart dis. DUE TO (c) II. 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"/>			
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) 9/8	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4200	
22. I hereby certify that I attended the deceased from 7/25/49, 19, to 8/15/49, 19, that I last saw the deceased alive on 8/15/49, 19, and that death occurred at 3:55am, from the causes and on the date stated above.			
23a. SIGNATURE William W. Carter M.D.		23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 8/15/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 17, 1949	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery	24d. LOCATION (City, town, or county) (State) 7901 Gravois ave.
DATE REG'D BY LOCAL AUG 16 1949	REGISTRAR'S SIGNATURE J. B. Lassiter	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister U. & L. Co. 7814 S. Broadway	

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 *Henry J. Selman*.....

Licensed Embalmer No. *9679*.....

P. O. Address *7874 E Broadway*.....

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.