No. 300
10-48

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35555

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9217

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

1. PLACE OF DEATH
a. COUNTY: 5800 Arsenal St.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis Mo.,
c. LENGTH OF STAY (in this place): 10 Mo 18 Da.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): City Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 26 1530 South Montgomery

3. NAME OF DECEASED (Type or Print)
a. (First): Lizzie
b. (Middle):
c. (Last): Schneider

4. DATE OF DEATH (Month) 10 (Day) 25 (Year) 49

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: August 8-1876
9. AGE (In years last birthday): about 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Louis Mo
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Jacob Schneider
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs. Glen Green 5226 Terry Ave.

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) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart
DUE TO (c) Disease

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 ☒ NO ☑

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) 98
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4251

22. *I hereby certify that I attended the deceased from* Dec. 7, 1948, *to* Oct. 25, 1949, *that I last saw the deceased alive on* Oct. 25, 1949 *and that death occurred at* 7:25 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Masao Ohmoto Om-Dr.
23b. ADDRESS: 5800 Arsenal
23c. DATE SIGNED: 10/25/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-28-49
24c. NAME OF CEMETERY OR CREMATORY: New Pickers Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis Mo

DATE REC'D BY LOCAL REG.: 10-26-49
REGISTRAR'S SIGNATURE: J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Leidner U. Co 2223 St. Louis Ave

(Licensed Embalmer's Statement on Reverse Side)

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. _____

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE
b. COUNTY
c. CITY (If outside corporate limits, write RURAL, and give township) OR TOWN
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last)
4. DATE OF DEATH (Month) (Day) (Year)
5. SEX
6. COLOR OR RACE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH
9. AGE (In years. Last birthday) Months Days If under 1 year: Hours Min. Sec.
10a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME
13b. MOTHER'S MAIDEN NAME
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause on 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 that caused death.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the immediate cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
19b. MAJOR FINDINGS OF OPERATION
19a. DATE OF OPERATION
INTERVAL BETWEEN ONSET AND DEATH

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 _____ working under my personal supervision.

Student Embalmer No. _____

Signed John P. Buckhalter

Licensed Embalmer No. 1674

P. O. Address 2223 Louisa

Student Embalmer _____ Signed _____

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.

20. AUTOPSY? Yes ☐ No ☐
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)
21d. HOW DID INJURY OCCUR
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
22. I hereby certify that I attended the deceased from _____, 19__ to _____, 19__, and that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.
23. SIGNATURE
24. ADDRESS (Degree or title)
25. DATE SIGNED
26a. BURIAL, CREMATION, REMOVAL (Specify)
26b. DATE
26c. NAME OF CEMETERY OR CREMATORY
DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE IN THIS SPACE

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