

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **11062**
 Registrar's No. **2210**

FILED MAR 16 1950

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 2210		
1. PLACE OF DEATH a. COUNTY ST. LOUIS				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. LENGTH OF STAY (In this place) 2 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 23 2249 Shenandoah Avenue		
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital,				d. STREET ADDRESS (If rural, give location) 23 2249 Shenandoah Avenue				
3. NAME OF DECEASED (Type or Print) PETER SCHNEIDER			4. DATE OF DEATH MARCH 5, 1950					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH March 26, 1873		
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR 11 Months 9 Days		IF UNDER 1 HRS. 0 Hours 0 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery Worker			10b. KIND OF BUSINESS OR INDUSTRY Lemp Brewery		11. BIRTHPLACE (State or foreign country) Murphysboro, Illinois		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Peter Schneider			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Margaret		
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 Clara Morris ADDRESS 5414 Delmar Blvd			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute hemorrhagic pancreatitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II: OTHER SIGNIFICANT CONDITIONS. Arteriosclerotic heart disease with cardiac decompensation. Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH 3 days. 2 years.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 5870 (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 Mar. 3, 1950 , to Mar. 5, 1950 , that I last saw the deceased alive on Mar. 5, 1950 , and that death occurred at 7:22 P. M. , from the causes and on the date stated above.								
23a. SIGNATURE F. Bradley (Degree or title) M.D.			23b. ADDRESS Barnes Hospital,			23c. DATE SIGNED 3/6/50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-8-50		24c. NAME OF CEMETERY OR CREMATORY Tower Grove		24d. LOCATION (City, town, or county) (State) Murphysboro, Illinois		
DATE REC'D BY LOCAL MAR 7 1950		REGISTRAR'S SIGNATURE J. B. Lassater		25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Funeral Home		ADDRESS 201 Lafayette		

(Motor)

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

X

Handwritten mark

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.....
Student Embalmer

Signed *James R. Chapman*
Licensed Embalmer No. *4550*

P. O. Address *St. Louis, 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.