

FILED SEP 13 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29222

State File No. ....

BIRTH NO. _____		REG. DIST. NO. <u>4</u>		PRIMARY REG. DIST. NO. <u>431</u>		Registrar's No. <u>61</u>	
1. PLACE OF DEATH a. COUNTY <u>Warren</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Warren</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrenton</u>		c. LENGTH OF STAY (in this place) <u>2 1/2 mon</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Warrenton</u>		<u>1090</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Katie James Memorial</u>				d. STREET ADDRESS (If rural, give location) <u>U</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mattie</u>		b. (Middle)		c. (Last) <u>Schneider</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 23 1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>		8. DATE OF BIRTH <u>June 16 1885</u>	
9. AGE (In years last birthday) <u>65</u>		# UNDER 1 YEAR Months		# UNDER 2 HRS. Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>In a Home</u>			11. BIRTHPLACE (State or foreign country) <u>Warren Co Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13a. FATHER'S NAME <u>August Mining</u>			13b. MOTHER'S MAIDEN NAME <u>Fannie Welch</u>			14. NAME OF HUSBAND OR WIFE <u>Anna Mining Wright City Mo</u>	
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. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Anna Mining Wright City 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Apoplexy.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Heart lesion.</u> DUE TO (c) <u>Myocarditis + Mitral lesion</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>(Supp report)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>68 days</u> <u>2 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>✓</u>				20. AUTOPSY? YES <input 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) (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 <u>June 16<sup>th</sup> 1950</u> , to <u>Aug 23<sup>rd</sup> 1950</u> , that I last saw the deceased alive on <u>Aug 11<sup>th</sup> 1950</u> , and that death occurred at <u>7 A. M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Walter H. Oyster, M.D.</u>				23b. ADDRESS <u>Warrenton Mo</u>		23c. DATE SIGNED <u>Aug. 23<sup>rd</sup> 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 24 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wright City Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Wright City Mo</u>	
DATE REC'D BY LOCAL REG. <u>Aug 23 1950</u>		REGISTRAR'S SIGNATURE <u>Floyd Logan</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Nieburg Furn &amp; Und Co</u>		ADDRESS <u>Wright City Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 360

10-48

090  
4

File No. \_\_\_\_\_  
DISTRICT HEALTH OFFICE No. 4

SEP - 7 1950

RECEIVED

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, *et al* by \_\_\_\_\_

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

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer \_\_\_\_\_

Signed \_\_\_\_\_

*Julius J. Nieburg*

Licensed Embalmer No. *3366*

P. O. Address *Wright City*

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.