

FILED DEC 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 36647

BIRTH NO. _____ REG. DIST. NO. 117 PRIMARY REG. DIST. NO. 5436 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY Gasconade		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Gasconade	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL BOURLEVAIRE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Boulevard Township 0370	
c. LENGTH OF STAY (In this place) 84yr		d. STREET ADDRESS (If rural, give location) R2 M. S.W. of Hermann, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home (Rural)			

3. NAME OF DECEASED (Type or Print) Marie Elisabeth Schneider			4. DATE OF DEATH (Month) (Day) (Year) 11 4 1950		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Sept. 7 1866		9. AGE (In years last birthday) 84		10. IF UNDER 1 YEAR Months Days 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 Farming		11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME Christian Klossner		13b. MOTHER'S MAIDEN NAME Ellen Meyer		14. NAME OF HUSBAND OR WIFE John Schneider Deceased	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ervin Schneider Bay, Mo	
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arteriosclerosis		
	DUE TO (c) Semility		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			334X

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)		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) (Min.)		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 10-28, 1950, to 11-3, 1950, that I last saw the deceased alive on 11-2, 1950, and that death occurred at 9:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE Howard Workman M.D. (Degree or title)		23b. ADDRESS Hermann Mo		23c. DATE SIGNED 11-6-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 11-6-50		24c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery	
		24d. LOCATION (City, town, or county) Little Bay Gasconade, Co.		(State) Mo.	

DATE REC'D BY LOCAL REG. 11/6/50		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [Signature] Mo.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

File No. _____
DISTRICT HEALTH OFFICE No. 4

DEC - 2 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, or by _____

working under my personal supervision.

Student Embalmer No.

Signed *Chas. N. Pope*

Signed
Student Embalmer

Licensed Embalmer No. 2552

P. O. Address Hermann, 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.