

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35582

9141

| | | | | | | | | | | | |
|--|------------------------|--|---|--|--|---|--------------------------------|---|------------------------------|--|--|
| BIRTH NO. | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (If deceased lived. If institution: residence before admission). a. STATE Mo. | | | | b. COUNTY | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) St. Louis | | c. LENGTH OF STAY (in this place) 3 1/2 yrs. | | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | 2129 | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 4511 McPherson Ave. | | | | d. STREET ADDRESS (If rural, give location) 4511 McPherson Ave. | | | | | | | |
| 3. NAME OF DECEASED a. (First) Anna | | | b. (Middle) E. | | c. (Last) Schneider | | | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 16, 1951 | | | |
| 5. SEX F | 6. COLOR OR RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W. | | 8. DATE OF BIRTH Mar. 6, 1888 | | 9. AGE (In years last birthday) 63 | IF UNDER 1 YEAR Months 7 | IF UNDER 24 HRS. Days 10 | Hours 10 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Greenwood Linen Importers | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Ill. | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13a. FATHER'S NAME John Brew | | | 13b. MOTHER'S MAIDEN NAME Margaret Carey | | | 14. NAME OF HUSBAND OR WIFE Charles A. Schneider | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT'S SIGNATURE OR NAME Mrs. W.R. Spencer, 4511 McPherson Ave. | | | | | ADDRESS | | |
| 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. | | | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) metastatic cancer | | | | INTERVAL BETWEEN ONSET AND DEATH 1 year | | | |
| | | | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cancer of breast | | | | 6 years | | | |
| | | | | 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) | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21f. HOW DID INJURY OCCUR? 170X | | | | | | |
| 22. I hereby certify that I attended the deceased from July 26, 1951, to Oct. 16, 1951, that I last saw the deceased alive on Oct. 15, 1951, and that death occurred at 1 a. m., from the causes and on the date stated above. | | | | | | | | | | | |
| 23a. SIGNATURE Mary S. Franklin | | | | (Degree or title) M.D. | | 23b. ADDRESS 634 N. Grand | | | 23c. DATE SIGNED 10/16/51 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE Oct. 18, 1951 | | 24c. NAME OF CEMETERY OR CREMATORY Galvary Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | | | | |
| DATE REC'D BY LOCAL REG. OCT 17 1951 | | REGISTRAR'S SIGNATURE J. Earl Smith M.D. | | | FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly | | | ADDRESS 3840 Lindell Blvd. | | | |

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

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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4699

P. O. Address [Signature]

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.