

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7927**
Registrar's No. **1255**

FILED FEB 25 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2109.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4421 Labadie Avenue		d. STREET ADDRESS (If rural, give location) 10 4421 Labadie Avenue	
3. NAME OF DECEASED (Type or Print) a. (First) VALENTINE b. (Middle) c. (Last) SCHNEIDER			4. DATE OF DEATH (Month) (Day) (Year) Feb 1, 1953
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH Feb 18, 1876
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months 11 Days 14	11. IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener (retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Schneider		13b. MOTHER'S MAIDEN NAME Ida Maltitz	
14. NAME OF HUSBAND OR WIFE Deceased			
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 Mr. Arthur Schneider		ADDRESS 4421 Labadie	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION Carcinoma, bile ducts (hepatic ducts) INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		ANTECEDENT CAUSES 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.		General senility	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 155X			
22. I hereby certify that I attended the deceased from Dec. 9, 1952 to Jan 29, 1953 , that I last saw the deceased alive on Jan 27, 1953 and that death occurred at 10:30 A. m. , from the causes and on the date stated above.			
23a. SIGNATURE (Deceased or title) Burke Eck M.D.		23b. ADDRESS 508 N. Grand	
23c. DATE SIGNED Feb. 3, 53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb 4, 1953	
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
DATE REC'D BY LOCAL REG. FEB 3 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Bromschwig and Son W Florissant		ADDRESS 4746	

Dr. Eck
Metropolitan Bldg.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. 3749

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.