

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **6573**

FILED MAR 8 1954
BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1559**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo b. COUNTY 2267	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 26 1904 Destrehan	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1904 Destrehan			

3. NAME OF DECEASED (Type or Print) Sophie Schneider-Miller			4. DATE OF DEATH (Month) (Day) (Year) Feb 16 1954		
a. (First)	b. (Middle)		c. (Last)		
F I	W	Widowed (Specify)	84		Feb 17 - 1869
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
House work		Own home		Columbia, Ill	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S

13a. FATHER'S NAME: Henry Schack		13b. MOTHER'S MAIDEN NAME Unknown		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 ADDRESS Ann Schneider - 1904 Destrehan	

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		INTERVAL BETWEEN ONSET AND DEATH 70 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		
	ANTECEDENT CAUSES DUE TO (b) Senility 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 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? 4222	

22. I hereby certify that I attended the deceased from Feb. 1, 1954, to Feb. 16, 1954, that I last saw the deceased alive on Feb. 15, 1954, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) S. C. Creanie M.D.		23b. ADDRESS 2504 No. 14th St.		23c. DATE SIGNED 2-16-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb 18 - 1954		24c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	
		24d. LOCATION (City, town, or county) (State) St. Louis County Mo			

DATE REC'D BY LOCAL REG. FEB 17 1954		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edw. Koch + Son - 2516 E. 14th	
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

0.300
0.48

100

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 Raymond O. Yohinke

Licensed Embalmer No. 3917

P. O. Address St. Louis

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.