

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10258**

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 <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>	c. LENGTH OF STAY (in this place) <b>16 hrs.</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? <b>Yes</b> <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Anthony Hospital</b>		STREET ADDRESS (If rural, give location) <b>4984a Mardel Avenue 21490</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Matilda</b>	b. (Middle) <b>A.</b>	c. (Last) <b>Schnell</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 11, 1954</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 13, 1877</b>
9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Frank Lettenecker</b>	13b. MOTHER'S MAIDEN NAME <b>Henrietta Streib</b>	14. NAME OF HUSBAND OR WIFE <b>George Schnell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Raymond B. Schnell-4984a Mardel Ave.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Heart Failure</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
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? <b>4200</b>	
22. I hereby certify that I attended the deceased from <b>Feb. 1, 1949</b> , to <b>Nov. 11, 1954</b> , that I last saw the deceased alive on <b>Nov. 11, 1954</b> , and that death occurred at <b>1:30P m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>W. Hoffmann</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>16 Hampton Village Plaza</b>	23c. DATE SIGNED <b>11-12-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Nov. 13, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New St. Marcus Ceme.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
DATE REC'D BY LOCAL REG. <b>NOV 12 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wacker-Belderle - 3634 Gravois Ave.</b>	

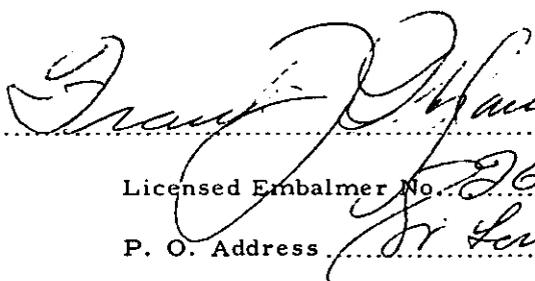
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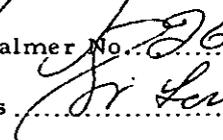
STATEMENT BY LICENSED EMBALMER

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 .....  
Signature of Student Embalmer

Signed ..... 

Licensed Embalmer No. ....

P. O. Address .....  


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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.