

FILED MAY 9 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13866

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3233

BIRTH NO. _____

1. PLACE OF DEATH
a. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS

c. LENGTH OF STAY (in this place) _____

c. CITY OR TOWN Ferguson ⁴¹⁰⁹

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital

STREET ADDRESS (If rural, give location) 606 Darst Rd.

3. NAME OF DECEASED
a. (First) Dennis b. (Middle) Michael c. (Last) Schneider

4. DATE OF DEATH (Month) (Day) (Year) April 9 1955

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH 3/6/54 9. AGE (In years last birthday) 17 IF UNDER 1 YEAR Months 1 Days _____ IF UNDER 24 HRS. Hour _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO. 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME William Schneider 13b. MOTHER'S MAIDEN NAME Dorothy Becker 14. NAME OF HUSBAND OR WIFE _____

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. _____ 17. INFORMANT'S SIGNATURE OR NAME William Schneider ADDRESS 606 Darst Rd.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post-operative shock,

ANTECEDENT CAUSES Megacolon.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) Resection of Colon

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 3 hours

19a. DATE OF OPERATION 4/9/55 19b. MAJOR FINDINGS OF OPERATION Megacolon & Resection of Colon. 20. AUTOPSY? YES NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 7562

22. I hereby certify that I attended the deceased from birth, 19____, to Apr 9, 1955, that I last saw the deceased alive on Apr 9, 1955, and that death occurred at 2:30 P. m., from the causes and on the date stated above.

23a. SIGNATURE John J. Shaney M.D. (Degree or title) 23b. ADDRESS 3720 Washington 23c. DATE SIGNED 4/11/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 4/12/55 24c. NAME OF CEMETERY OR CREMATORY Cadaver Cemetery 24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO

DATE REC'D BY LOCAL REG. APR 11 1955 REGISTRAR'S SIGNATURE J. Cash Smith M.D. FUNERAL DIRECTOR'S SIGNATURE Walter J. Collier ADDRESS General Home 10123 St. Charles Rd.

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W E Morris*.....

Licensed Embalmer No. *336*

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