

FILED APR 27 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15032

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 971

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY OR TOWN <u>Clayton Mo.</u>		c. CITY OR TOWN <u>Univ. City, Mo.</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>3da</u>		e. STREET ADDRESS (If rural, give location) <u>6313 Cabanne</u>	
d. FULL NAME OF (if not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St. Louis Co. Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Wolf</u> b. (Middle) <u>Schneider</u> c. (Last) <u>Schneider</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 10, 1956</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u>	8. DATE OF BIRTH <u>unk</u>	9. AGE (In years last birthday) <u>78</u>	10. IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tailoring/Ind</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>unk</u>	13b. MOTHER'S MAIDEN NAME <u>unk</u>	14. NAME OF HUSBAND OR WIFE <u>Tillie Schneider</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>unk</u>	17. INFORMANT'S SIGNATURE OR NAME <u>W. F. Tillie Schneider</u> ADDRESS <u>6313 Cabanne</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from 4-7, 1956, to 4-10, 1956, that I last saw the deceased alive on 4-10, 1956, and that death occurred at 10:00 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Joseph G. Crut M.D.</u>	23b. ADDRESS <u>601 S. Brentwood, Clayton, Mo.</u>	23c. DATE SIGNED <u>4-10-1956</u>
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24a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>burial</u>	24b. DATE <u>4-11-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cheura Kadisha</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>4-11-56</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donke</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Matthewman Rindskopf, Inc.</u> ADDRESS <u>8216 Delmar P.</u>
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(Licensed Funeral Home's Statement on Reverse Side)

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

**A 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 *Peter B. Duboullé*  
Licensed Embalmer No. *36*

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.