

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045064

STATE FILE NUMBER

FILED JAN 6 1959 Registration District No. 257 Primary Registration District No. 8881 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY Osage		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Osage	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jefferson Twp.		c. CITY OR TOWN Bland Route	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Farm Home		d. STREET ADDRESS (If outside, give location) near Cooper Hill	
3. NAME OF DECEASED (Type or print) First Joseph Middle William Last Schneider		4. DATE OF DEATH Month Dec. Day 30 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-16-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (City and state or country) Cooper Hill, Mo.	
13a. FATHER'S NAME William Schneider		14. NAME OF HUSBAND OR WIFE Schneider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI		17. INFORMANT Mrs. Amanda Schnedier	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Anemia DUE TO (b) Coronary Artery Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 5-12	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 4261	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 5-57 to 12-30-58 and last saw him alive on 12-23-58 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
21a. SIGNATURE Chas. Schmidt		22b. ADDRESS Beard	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery	
23b. DATE 1-3-1959		23d. LOCATION (City, town, or county) (State) Cooper Hill, Mo.	
24. FUNERAL DIRECTOR Wilford H. H. Winters		25. DATE RECD. BY LOCAL REG. Jan. 3-1959	
ADDRESS OWENSVILLE		26. REGISTRAR'S SIGNATURE Mrs. T. A. Dubrouillet	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

