

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007615  
STATE FILE NUMBER  
2 1743  
Registrar's No.

FILED MAR 10 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Texas</i> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Dallas</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Hamilton Med. Center</i>		Length of stay in 1b	d. STREET ADDRESS <i>401 N. Winneka Av.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>ANNA SCHNEIDER</i>			4. DATE OF DEATH Month Day Year <i>Feb. 15th, 1959</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 23, 1862</i>	9. AGE (In years last birthday) <i>96</i> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (City and state or country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13a. FATHER'S NAME <i>William Keller</i>		13b. MOTHER'S MAIDEN NAME <i>Theresa Laumann</i>		14. NAME OF HUSBAND OR WIFE <i>Andrew Schneider</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no none</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT Address <i>Mr. F. J. Schneider 8720 Granada Pl.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c) <i>420.0</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <i>April 22, 1957</i> to <i>Feb. 15, 1959</i> and last saw <sup>her</sup> alive on <i>Feb. 14, 1959</i> Death occurred at <i>11:10 P.</i> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Henry C. Westerman, M.D.</i>		(Degree or title)	22b. ADDRESS <i>2136 East Grand Ave</i>		22c. DATE SIGNED <i>2-17-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<i>Burial</i>	<i>Feb. 19/59</i>	<i>Calvary Cemetery</i>		<i>St. Louis, Missouri</i>	
24. FUNERAL DIRECTOR <i>JOHN STYGAR &amp; SON</i>		ADDRESS <i>5541 RIVERVIEW BLVD.</i>	25. DATE RECD. BY LOCAL REG. <i>FEB 18 '59</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, *[Handwritten Signature]* .....

Licensed Embalmer No. *3980* .....

P. O. Address, *St. Louis, Mo.* .....

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.