

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023635

STATE FILE NUMBER

FILED JUL 3 1959

Registration District No. 317

Primary Registration District No. 544

Registrar's No. 1730

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> )	
b. CITY OR TOWN <b>Kirkwood</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Maplewood</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hosp.</b>		Length of stay in lb <b>1 mo.</b>	d. STREET ADDRESS (If outside, give location) <b>7231 Sarah St.</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) <b>NORA J. SCHNEIDER</b>	First Middle Last	4. DATE OF DEATH <b>June 27, 1959</b>	Month Day Year
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29,</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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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 country) <b>St. Louis County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Robert Stewart</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Coughlin</b>	14. NAME OF HUSBAND OR WIFE <b>Fred J. Schneider</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Broncho Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 da 2 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>cholecystectomy</b>	<b>16 da 2 hr</b>
	DUE TO (c) <b>Secondary round cancer 586X</b>	<b>7 da 15 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Asteris sclerotic heart disease</b>		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.)
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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
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21. I attended the deceased from Death occurred at <b>5-31-59 12 noon</b>	and last saw her alive on <b>6-27-59 11:20 am</b>
on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <b>H. J. Shuckey M.D.</b>	(Degree or title)	22b. ADDRESS <b>25 27 Laclede Hall</b>	22c. DATE SIGNED <b>6-29-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>June 30, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>
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24. FUNERAL DIRECTOR <b>M.J. Croghan, 7146 Manchester Ave.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>6-29-59</b>	26. REGISTRAR'S SIGNATURE <b>John P. Murphy, M.D.</b>
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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 *J. A. Wilson*  
Licensed Embalmer No. *329*  
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.