

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS AUG 11 1959

59-027168

Registration District No. _____ Primary Registration District No. _____ Registrar No. **7027** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Missouri b. COUNTY	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 200 north 11th Street		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) DeSoto Hotel 200 N. 11th	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Caroline Middle (none) Last Schneider	4. DATE OF DEATH Month July Day 28 Year 1959
---	--

5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/24/1871	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-------------------------	----------------------------------	---	---------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Belleville Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	--	--	--

13a. FATHER'S NAME Phillip Muench	13b. MOTHER'S MAIDEN NAME Cathern Steinhauer	14. NAME OF HUSBAND OR WIFE John A. Schneider
---	--	---

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. none	17. INFORMANT Irma E. Schneider 200 north 11th st.	Address
---	--	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Arterio-Sclerotic Heart Disease		long standing
DUE TO (b)		
DUE TO (c)		420.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		
PART III. If deceased was female was there a pregnancy in last 90 days.		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ a.m. _____ p.m.	Month, Day, Year
---	------------------

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 **Jan 2 - 1957** to **July 28 - 69** and last saw her alive on **1957**
 Death occurred at **July 28 - 1959 6 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>LeMay</i>	(Degree or title)	22b. ADDRESS 812 Olive St. St. Louis 20	22c. DATE SIGNED 7-27-59
--------------------------------	-------------------	---	------------------------------------

23a. BURIAL, CREMATION REMOVAL (Specify) removal	23b. DATE 8-1-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Catholic Cemetery	23d. LOCATION (City, town, or county) (State) Lemay Missouri
--	----------------------------	--	--

24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar Blv'd.	ADDRESS	25. DATE RECD. BY LOCAL REG. JUL 29 1959	26. REGISTRAR'S SIGNATURE <i>Earl Smith M.D.</i>
--	---------	--	---

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arnold W. Schoes

Licensed Embalmer No. 3864
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.