

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-003006

FILED VS. JAN 26 1960 310

Registration District No. Primary Registration District No. 3058 Registrar's No. 16

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Charles</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in lb <u>5 days</u>		c. CITY OR TOWN <u>O'Fallon, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>615 North Main</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>Joseph</u> Last <u>Schneider</u>				4. DATE OF DEATH Month <u>1</u> Day <u>18</u> Year <u>60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-9-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>St. Peters, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>George Schneider</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Pieper</u>		14. NAME OF HUSBAND OR WIFE <u>Clara Marie Schneider</u>		
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>489-28-1299</u>		17. INFORMANT Address <u>Clara Marie Schneider, O'Fallon Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (b), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>							<u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) <u>Generalized Arteriosclerosis with:</u>							
DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							
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 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>  </u> <u>  </u> <u>  </u>					
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 <u>Aug 1954</u> to <u>17 Jan 1960</u> and last saw her/him alive on <u>17 Jan 1960</u> Death occurred at <u>9 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Gene J. DuMontre M.D.</u> (Degree or title)				22b. ADDRESS <u>O'Fallon Mo</u>		22c. DATE SIGNED <u>1-20-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>January 21, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Assumption Catholic Cent</u>		23d. LOCATION (City, town, or county) (State) <u>O'Fallon Missouri</u>			
24. FUNERAL DIRECTOR <u>Charles J. Callahan</u>		ADDRESS <u>O'Fallon Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>1/20/60</u>	26. REGISTRAR'S SIGNATURE <u>Marella Wilson</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 27 1960

STATEMENT BY LICENSED EMBALMER

APR 27 1960

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 Charles J. Callahan

Licensed Embalmer No. Permit

P. O. Address O'Fallon

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.