

# IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-017313

FILED VS APR 22 1960

Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

2 3998

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis,</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony Hospital,</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri,</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis,</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>5034 Idaho Ave.,</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Oscar</b> Middle <b>Schneider,</b> Last _____			<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>9,</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Male.</b>	<b>6. COLOR OR RACE</b> <b>White,</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9/16/1887</b>	<b>9. AGE (last birthday)</b> <b>72</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HR</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Blacksmith,</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired 27 Years,</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Vienna, Austria,</b>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		<b>13a. FATHER'S NAME</b> <b>John Schneider</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Elizabeth - - - - -</b>			
<b>14. NAME OF HUSBAND OR WIFE</b> <b>Helen Schneider,</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					
<b>16. SOCIAL SECURITY NO.</b> <b>497-38-6598</b>		<b>17. INFORMANT</b> Address <b>Helen Schneider, 5034 Idaho Ave.,</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>420.1</b>					INTERVAL BETWEEN ONSET AND DEATH _____		
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of Item 18.) _____			
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____ <b>STATE</b> _____			
<b>21. I attended the deceased from</b> <b>4/4/60</b> to <b>4/9/60</b> and last saw <b>her</b> alive on <b>4/8/60</b> • Death occurred at <b>5:25 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <i>J. Grant M.D.</i>			<b>22b. ADDRESS</b> <b>5521 S. Poling</b>		<b>22c. DATE SIGNED</b> <b>4/11/60</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal.</b>		<b>23b. DATE</b> <b>4/12/60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Resurrection Cemetery,</b>			
<b>23d. LOCATION</b> (City, town, or county) <b>St. Louis County, Mo.</b>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Gebken-Benz Mortuary, 2842 Meramec St., St. Louis, 18, Mo.</b>					
<b>25. DATE RECD. BY LOCAL REG.</b> <b>APR 11 1960</b>			<b>26. REGISTRAR'S SIGNATURE</b> <i>Roal Smith, M.D.</i>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 \_\_\_\_\_ me \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_  
*Joe B. Benz*

Licensed Embalmer No. 4249  
2842 Meramec  
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.