

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo.</u> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                           |  | c. CITY OR TOWN <u>St. Louis</u>   |  |
| Length of stay in lb  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>D.O.A. Deaconess Hospital</u> |  | d. STREET ADDRESS (If outside, give location)<br><u>5055 Rhodes Ave.</u>   |  |
| Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                                       |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>HARRY</u> Middle <u>J.</u> Last <u>SCHNEIDER</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>Dec.</u> Day <u>1</u> Year <u>1960</u> |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>10-13-1893</u>                               | 9. AGE (last birthday)<br><u>67</u>                     | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Structural Steel Worker (Retired)</u> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><u>St. Louis, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A.</u>            |   |
| 13a. FATHER'S NAME<br><u>George Schneider</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Nellie McMahon</u>  |   | 14. NAME OF HUSBAND OR WIFE<br><u>Pauline Schneider</u> |   |

|   |   |  |
|---|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u> | 16. SOCIAL SECURITY NO.<br><u>493-10-6772</u> | 17. INFORMANT<br><u>Pauline Schneider 5055 Rhodes Ave.</u> |
|---|---|--|

|  |  |                                  |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: |  | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Coronary occlusion;</u>   |  |                                  |
| DUE TO (b) <u>Coronary Sclerosis</u>   |  |                                  |
| DUE TO (c) <u>420.1</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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|--|--|

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.<br>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<br>COUNTY STATE |
|--|--|--|

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 9:30 a m on the date stated above, and to the best of my knowledge, from the causes stated.

|   |                                   |                                    |
|---|-----------------------------------|------------------------------------|
| 22a. SIGNATURE<br><u>Patrick E Taylor coroner</u> (Degree or title) | 22b. ADDRESS<br><u>1300 Clark</u> | 22c. DATE SIGNED<br><u>12-2-60</u> |
|---|-----------------------------------|------------------------------------|

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>Dec. 5, 1960</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Calvary Cemetery</u> | 23d. LOCATION (City, town, or county) (State)<br><u>St. Louis, Mo.</u> |
|--|----------------------------------|---|--|

|  |   |  |
|--|---|--|
| 24. FUNERAL DIRECTOR<br><u>Kriegshauser 4228 S. Kingshighway Blvd.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>DEC 2 1960</u> | 26. REGISTRAR'S SIGNATURE<br><u>Earl Smith, M.D.</u> |
|--|---|--|

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

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

Signed RW. Storrans

Licensed Embalmer No. 4007

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.