

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-020486

STATE FILE NUMBER

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 607

FILED JUN 19 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph		Length of stay in 1b 65 Yrs.	c. CITY OR TOWN St. Joseph Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Methodist Hospital		Inside Limits: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) #38 Ridgelande Road Country Club Place Reside on Farm: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Lawrence Middle Nicholas Last Schneider	4. DATE OF DEATH Month June Day 11 Year 1961
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1894	9. AGE (last birthday) 67	IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prs. Midwest Savings & Loan	10b. KIND OF BUSINESS OR INDUSTRY Savings and Loan	11. BIRTHPLACE (City and state or country) Andrew County Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME William John Schneider	13b. MOTHER'S MAIDEN NAME Elizabeth A. Lehman	14. NAME OF HUSBAND OR WIFE Edna M. Schneider
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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) Yes W. W. #1	17. INFORMANT Mrs. Edna M. Schneider-St. Joseph, Mo.
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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) Ventricular fibrillation		INTERVAL BETWEEN ONSET AND DEATH 48 hours
DUE TO (b) ;		
DUE TO (c) Hemorrhage - Esophageal varices		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pale cyanosis of the liver.	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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year
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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 St. Joseph, Mo. COUNTY Buchanan STATE Missouri
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21. I attended the deceased from **6-10-61** to **6-11-61** and last saw her/him alive on **6-11-61**
Death occurred at **7:25 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Lucia K. Ide M.D.	22b. ADDRESS 902 Edmond St - Joseph, Mo.	22c. DATE SIGNED 6-14-61
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23a. BURIAL INFORMATION, REMOVAL (Specify) Burial	23b. DATE June 14, 1961	23c. NAME OF CEMETERY, OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) St. Joseph, Mo. (State)
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24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc. St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. June 15, 1961	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF **L.W. Ide, M.D.** MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

JUN 20 1961

AUG 21 1962

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 Raymond P. Hoover

Licensed Embalmer No. 5147

P. O. Address St Joseph

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.