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STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

FILED AUG 14 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY WARREN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b 3 DAYS	c. CITY OR TOWN WRIGHT CITY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMIN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) RR 2, BOX 151a
3. NAME OF DECEASED (Type or print) First WILLIAM Middle A. Last SCHNEIDER			4. DATE OF DEATH Month 8 Day 3 Year 61
5. SEX MALE	6. COLOR OR RACE CAU	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-12-94
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICKMASON		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	9. AGE (last birthday) 67
13a. FATHER'S NAME GEORGE C. SCHNEIDER		13b. MOTHER'S MAIDEN NAME IDA BRAMBLE	12. CITIZEN OF WHAT COUNTRY USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		14. NAME OF HUSBAND OR WIFE DOLLY SCHNEIDER	
17. INFORMANT DOLLY SCHNEIDER RR 2, BOX 151a			Address WRIGHT CITY MISSOURI
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION</u> DUE TO (b) <u>CARCINOMA OF TRACKIA WITH TRACHEO ESOPHAGEAL FISTULA.</u> DUE TO (c) <u>162,0</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 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		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>7-31-61</u> to <u>8-3-61</u> . Death occurred at <u>10:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (If degree or title) <i>[Signature]</i> MD, VETERANS ADMINISTRATION HOSP. 915 N. GRAND BLVD		22b. ADDRESS	22c. DATE SIGNED 8/3/61
23a. BURIAL, CREMATION, REBURYAL (Specify) Removal	23b. DATE 8/7/1961	23c. NAME OF CEMETERY OR CREMATORY Lake Charles	23d. LOCATION (City, town, or county) (State) St Louis Mo
24. FUNERAL DIRECTOR Ortmann F Home 9222 Lackland Overland Mo		25. DATE RECD. BY LOCAL REG. AUG 4 1961	26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M.D.

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 Al. C. Ortman

Licensed Embalmer No. 3478

P. O. Address _____

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.