

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-025163

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6498**

JUL 6 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>                                                                                                                                                                                          |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY                                      |                                                                                                                                                                                 |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>St. Louis</b>                                                                                                                                                            |                                                                                                           | c. CITY OR TOWN <b>St. Louis</b>                                                                                                                            |                                                                                                                                                                                 |
| Length of stay in lb <b>53 days</b>                                                                                                                                                                                                      |                                                                                                           | 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 <b>St. Louis Chronic</b>                                                                                                                                  |                                                                                                           | d. STREET ADDRESS (If outside, give location)<br><b>1904 Dresttrahan</b>                                                                                    |                                                                                                                                                                                 |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Anna</b> Middle <b>M. Schneider</b> Last                                                                                                                                                 |                                                                                                           | 4. DATE OF DEATH<br>Month <b>6</b> Day <b>30</b> Year <b>62</b>                                                                                             |                                                                                                                                                                                 |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                  | 6. COLOR OR RACE<br><b>White</b>                                                                          | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-2-88</b>                                                                                                                                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House work</b>                                                                                                                         |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>                                                                                                        | 11. BIRTHPLACE (City and state or country)<br><b>Illinois</b>                                                                                                                   |
| 13a. FATHER'S NAME<br><b>Theodore Schneider</b>                                                                                                                                                                                          |                                                                                                           | 13b. MOTHER'S MAIDEN NAME<br><b>Sophie Schack</b>                                                                                                           | 14. NAME OF HUSBAND OR WIFE<br><b>Divorced</b>                                                                                                                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>                                                                                                                    |                                                                                                           | 17. INFORMANT<br><b>Arthur Beaujean - 1904 Dresttrahan</b>                                                                                                  |                                                                                                                                                                                 |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anterioschrotic Heart Disease</b>                                                                                           |                                                                                                           |                                                                                                                                                             | INTERVAL BETWEEN ONSET AND DEATH<br><b>420.0</b>                                                                                                                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Chronic Brain Syndrome - Chronic</b>                                                             |                                                                                                           |                                                                                                                                                             | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" 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 <b>5:30 P.M.</b> 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 COUNTY STATE                                                                                                                   |                                                                                                                                                                                 |
| 21. I attended the deceased from <b>5-8-62</b> to <b>6-30-62</b> and last saw her/him alive on <b>6/30/62</b><br>Death occurred at <b>5:30 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |
| 22a. SIGNATURE (Degree or title)<br><b>Guy Huggins, M.D.</b>                                                                                                                                                                             |                                                                                                           | 22b. ADDRESS<br><b>634 W. Grand.</b>                                                                                                                        |                                                                                                                                                                                 |
| 22c. DATE SIGNED<br><b>7-2-62</b>                                                                                                                                                                                                        |                                                                                                           |                                                                                                                                                             |                                                                                                                                                                                 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>                                                                                                                                                                              | 23b. DATE<br><b>July 3, 1962</b>                                                                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Friedens Cemetery</b>                                                                                              | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County Mo</b>                                                                                                     |
| 24. FUNERAL DIRECTOR<br><b>Ear Koch + Son - 3516 &amp; 14th</b>                                                                                                                                                                          |                                                                                                           | 25. DATE RECD. BY LOCAL REG.<br><b>JUL 2 1962</b>                                                                                                           | 26. REGISTRAR'S SIGNATURE<br><b>Roald Smith, M.D.</b>                                                                                                                           |

USE BLACK INK OR OR TYPewriter RIBBON



**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 *V E Morris*

Licensed Embalmer No. 3360

P. O. Address St. Louis, Mo

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.