

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12407-62-048721
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED JAN 2 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

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>30 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5631 Park Lane</u>		d. STREET ADDRESS (If outside, give location) <u>5631 Park Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE AGNES SCHNEIDER</u>		4. DATE OF DEATH Month Day Year <u>Dec. 24 1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/10/1885</u>
9. AGE (last birthday) <u>77 years</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>Joseph Steppe</u>	
13b. MOTHER'S MAIDEN NAME <u>Lydia Strouback</u>		14. NAME OF HUSBAND OR WIFE <u>Lorenz Schneider</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT Address <u>Lorenz Schneider - 5631 Park Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			
DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? 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.) <u>420'D</u>	
20c. TIME OF INJURY Hour a.m. p.m. 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 <u>9/5/61</u> to <u>12/24/62</u> and last saw her ^{her} alive on <u>12/24/62</u> Death occurred at <u>2:15 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Do not write in this space) <u>Carl W. Jones, M.D.</u>		22b. ADDRESS <u>6000 WEST FLORISSANT</u>	
22c. DATE SIGNED <u>12/24/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>Dec 27, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	
23d. LOCATION (City, town, or county) <u>St. Louis Missouri</u>		23e. STATE	
24. FUNERAL DIRECTOR ADDRESS <u>BUCHHOLZ MORTUARY-5967 W. Florissant Ave</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 26 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>			

USE BLACK INK OR TYPEWRITER RIBBON

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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 Royal E. Heinders

Licensed Embalmer No. 4275

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.