

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017247

STATE FILE NUMBER

Registration District No. 310 Primary Registration District No. 6051 Registrar's No. 121

FILED APR 29 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59	DATE AMENDED	
1 0920		
2 0920		
3		
4 0		
5 1		
6		
7 0		
8 2		
9 163X		
10		
11		
12 90-0		
13 4-0		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Peters</u>		Length of stay in 1b <u>38 years</u>	c. CITY OR TOWN <u>St. Peters</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>Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. 1</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>Augustine</u> Last <u>Schneider</u>			4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1963</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>8-26-1900</u>
		9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>
			IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M.D.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>	11. BIRTHPLACE (City and state or country) <u>St. Peters Mo</u>
			12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Aloys Schneider</u>		13b. MOTHER'S MAIDEN NAME <u>Emily S. Weinwerth</u>	14. NAME OF HUSBAND OR WIFE <u>Anna M. Schneider</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W. 99-1</u>	17. INFORMANT Address <u>Mrs. Anna M. Schneider St. Peters Mo</u>
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>Pulmonary hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of lung</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>3 months</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 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 Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>			
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>January 1963</u> to <u>April 10, 1963</u> and last saw ^{her} him alive on <u>April 7, 1963</u> Death occurred at <u>2:15 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Justin B. Swollen M.D.</u>		22b. ADDRESS <u>207 N 5th St. St. Charles Mo</u>	22c. DATE SIGNED <u>4/15/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>15 Apr. 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Peters Mo.</u>
24. FUNERAL DIRECTOR <u>Prinster-Baue F.H.</u>		ADDRESS <u>St. Charles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>4-13-63</u>
26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>			<u>4/13/63</u>

USE BLACK INK OR TYPEWRITER RIBBON

AUG 2 1963

APR 30 1963

6-10-63

1-1-63

6-10-63

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 Frederic W. Paul

Licensed Embalmer No. 4607

P. O. Address St. Paul, 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.