DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13363

MAY 15 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3565

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County: St. Louis

(b) City or town: (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Masonic Home Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: (Specify whether years, months or days)
In this community: One year

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County:

(c) City or town: St. Louis 12
(If outside city or town limits, write "RURAL")

(d) Street No.: 5351 Delmar Blvd.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: William Henry Snyder 526

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: CHRISTIANA

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: Mar. 19, 1860 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
80		29	hr. min.

9. Birthplace: Hannibal, (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER

12. Name: Frederick Snyder

13. Birthplace: (City, town, or county) Germany (State or foreign country)

MOTHER

14. Maiden name: Fredricka Holsman

15. Birthplace: (City, town, or county) Germany (State or foreign country)

16. (a) Informant's own signature: Fannie Spence

(b) Address: 5351 Delmar Blvd., St. Louis, Mo.

17. (a) (Burial, cremation, or removal) (b) Date thereof: 4-19-40 (Month) (Day) (Year)

(c) Place: burial or cremation: CENTER, MO.

18. (a) Signature of funeral director: [illegible]

(b) Address: CENTER, MO.

19. (a) APR 19 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 18. year 1940 hour 4.05 minute P. M. M.

21. I hereby certify that I attended the deceased from April 13. 1939, to April 18. 1940; that I last saw him alive on April 18 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 Wk
Due to Hypertension	1 yr.
Chr. Interstitial	
Due to Nephritis	1 yr.
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Robert Cameron (M. D. or other)

Address: 508 N. Grand Blvd. Date signed:

(Licensed Embalmer's Statement on Reverse Side)

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 _____, Registered Apprentice No. _____ working under my personal supervision.

Signed John J Fetter

Licensed Embalmer No. 3880

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.