

S. No. 2
M-1.4-41
v. 5-17-39
X26390

20027

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 5842

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County None

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

(c) Name of hospital or institution:
Home of The Friendless-4431 S. Broadway
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Years
(Specify whether years, months or days)

In this community Lifetime 73 years

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County None

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

(d) Street No. 4431 S. Broadway
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3. (a) PRINT FULL NAME Elizabeth Sarah Sneed

3. (b) If veteran, name war None

3. (c) Social Security No None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9th
year 1942 hour 8 minute 50 M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Dr. Arthur Lewis Sneed 6. (c) Age of husband or wife in years 75

7. Birth date of deceased January 4, 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 30 to July 9 1942
that I last saw him alive on July 3 1942
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>6</u>	<u>5</u>	hr. _____ min. _____

Immediate cause of death

Arteriosclerosis 3 yrs
Chronic Bronchitis 3 yrs
Hypertension 3 yrs
Senile Dementia 3 yrs

Due to Senility

Other conditions (Include pregnancy within 3 months of death)

9. Birthplace Unknown Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business Housewife

Major findings: Of operations no 106

Of autopsy no

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Edward Cleaver

13. Birthplace Unknown England
(City, town, or county) (State or foreign country)

14. Maiden name Anna Caroline

15. Birthplace Unknown Switzerland
(City, town, or county) (State or foreign country)

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

(a) Accident, suicide, or homicide (specify) no

(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? _____

16. (a) Informant Edw. R. Sneed

(b) Address 4228 Roland Blvd

17. (a) Burial (b) Date thereof 7/11/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cemetery

18. (a) Signature of funeral director C. H. Meister U. & L. Co.

(b) Address 6464 Chippewa Street

19. (a) JUL 10 1942 (b) J. F. Medved
(Date received for recording) (Registrar's signature)

While at work? _____ (Specify type of place)

(d) Means of injury _____

23. Signature Chas. Hardman (M. D. or other) MD

Address 3720 Washington Date signed 7/8/42

(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 *Edwin H. Leisinger*

Licensed Embalmer No. *4049*

P. O. Address *6464 Chippewa*

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 this body is not embalmed, fact should be so stated above.