

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 15 1944

Registration District No. 3

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

12201

State File No.

Registrar's No. 867

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution 5 hrs. 35 min.
(Specify whether years, months or days)
In this community _____

3. (a) PRINT FULL NAME Charles Snider

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 Wid.
6. (b) Name of husband or wife Mamie Snider (Dec.) 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 9-16-1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 6 24 hr. min.

9. Birthplace Washington Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

12. Name Johnathon Snider
13. Birthplace Unknown Kansas
(City, town, or county) (State or foreign country)
14. Maiden name Savina Roberts
15. Birthplace Whelling W. Virginia
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Carl Budde
(b) Address 4946 Aldine Ave
17. (a) Burial (b) Date thereof 4-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director W. J. Harrison
(b) Address 4228 So. Pershingway
19. (a) APR 11 1944 (b) W. J. Harrison
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town University City
(If outside city or town limits, write "RURAL")
(d) Street No. 6603 Delmar Blvd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4-9-44 day _____
year _____ hour 4:35 minute _____ P. M.

21. I hereby certify that I attended the deceased from 4-9-44, 19____, to 4-9-44, 19____;
that I last saw him alive on 4-9-44, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary edema Duration 5 hrs.
Due to Arteriosclerotic Heart Disease ?

Due to Ca of prostate ?

Other conditions Secondary anemia
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy Ca prostate
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 Becki Masunaga (M. D. or other) M. D.
Address St. Louis County Hospital Date signed 4/10/44

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.....

Richard W. Howard

Licensed Embalmer No.....

P. O. Address.....

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.