

FILED JUL 15 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

120294

1. PLACE OF DEATH

County..... Registration District No. **318**
Township *St. Louis* Primary Registration District No. **1003**
City *Missouri - Faith Hospital*File No.....
Registered No. **6101**
St. Ward)

2. FULL NAME

Baby Venita Agnes Snyder(a) Residence No. *4512 N. Broadway* Ward.....
(Usual place of abode)Length of residence in city or town where death occurred *0* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Baby*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 8, 1944*7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) *Faith Hospital*
(STATE OR COUNTRY) *2800 N. Taylor, City*10. NAME OF FATHER *Lourence Snyder*11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Springdale, New York*
(STATE OR COUNTRY)12. MAIDEN NAME OF MOTHER *Venita Bach*13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *St. Louis, Mo.*
(STATE OR COUNTRY)14. INFORMANT *Lorraine Schindler*
(Address) *10026 Greary Drive*15. FILED **JUL 10 1944**
J. F. Brueck
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 9* 19*44*17. I HEREBY CERTIFY, That I attended deceased from *July 8* 19*44*, to *July 9* 19*44*, that I last saw him alive on *July 9* 19*44*, and that death occurred, on the date stated above, at *10:15 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

meningitis caused by deformity at time of Birth
(duration) *9* yrs. mos. da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....WAS THERE AN AUTOPSY? *no*WHAT TEST CONFIRMED DIAGNOSIS? *Optic Sign*(Signed) *Dr. H. B. Miller*, M. D., 19 (Address) *8410 N Broadway*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

*Calvary Cem.**July 12th 1944*

20. UNDERTAKER

ADDRESS

*Edward Koch**35164 14th**St Louis Mo*

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

No Embarking