S. No. 2
M—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 27310

FILED SEP 12 1944

Registration District No. 12 1944 Primary Registration District No. 1000 Registrar's No. 890

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Joseph's Hosp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 2 Mo. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St Joseph (If outside city or town limits, write "RURAL")
(d) Street No. 1706 So 12th (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Lawrence Anthony Snyder
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 Single
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased July (Month) 4 (Day) 1944 (Year)

8. AGE: Years 0 Months 2 Days 2 If less than one day ..... hr. ..... min.

9. Birthplace St Joseph (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation At Home
11. Industry or business .....
FATHER
12. Name William B. Snyder
13. Birthplace St Paul (City, town, or county) Minn (State or foreign country)
MOTHER
14. Maiden name Helen M. West
15. Birthplace Stafford (City, town, or county) Mo. 0 (State or foreign country)
16. (a) Informant Wm B. Snyder
(b) Address St Joseph, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Olivet
18. (a) Signature of funeral director Fleeman & Son Inc
(b) Address St Joseph, Mo.
19. (a) 9/7/44 (Date received local registrar) (b) Helen J. Pickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 6 year 1944 hour 7 minute 15 A M.
21. I hereby certify that I attended the deceased from 9-5-44 ....., 19...., to 9-6-44, 19....; that I last saw him alive on 9-5-, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Congenital Sues	Life time
Due to Intestinal Obstr	few days
Due to Hepatitis	" "
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 30 b
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 N E Grimes (M. D. [illegible])
Address ..... Date signed 9/6/44

1377

(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 Robert L Yapp

Licensed Embalmer No. 3308

P. O. Address St Joseph, 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 this body is not embalmed, fact should be so stated above.