

UNITED STATES HEALTH DEPARTMENT
STANDARD CERTIFICATE OF DEATH
1003

State File No. 948
Registrar's No. 537

FILED JAN 25 1948
318
Registration District No. 318

Primary Registration District No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
3135

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
322 North Boyle Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Margaret Snyder

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W. 6. (a) Single, widowed, married, divorced W. 2

6. (b) Name of husband or wife Frank X. Snyder 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 13, 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>3</u>	<u>3</u>	_____ hr. _____ min.

9. Birthplace Maxville Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Michael Hampel

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Kissler

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Emma Snyder

(b) Address 322 N. Boyle Ave.

17. (a) Burial (b) Date thereof 1-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Arthur J. Kannelly

(b) Address 3840 Lindell Blvd.

19. (a) JAN 17 1948 (b) _____ (c) _____
(Date of death) (Date of registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000

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

(d) Street No. 322 North Boyle Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 16
year 1946 hour 12 minute 55 P. M.

21. I hereby certify that I attended the deceased from Jan 1 1946 to January 16 1946
that I last saw her alive on January 16 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 1 day

Due to Chronic Myocarditis

with cardiac Hypertrophy 4 yrs

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

Signature A. J. Ragunovich M.D. or other _____
Address 4340 West Pine Bl Date signed 1-16-46

4390 West Pine Blvd.
RAEMONDONCK

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3845 Linsdale

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.