No. 2
-1/47
-17-39

#81445

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED FEB 9 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 3195

Registrar's No. 983

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether
In this community 55 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 0-00
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 702 N. 4th St., 9
Memorial (If rural, give location) 5
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ALVIN SNYDER
3. (b) If veteran, name war
3. (c) Social Security No. OAA
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 April (Month) 7th (Day) Unk. (Year)

8. AGE: Years abt - 76 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Pa. (State or foreign country)
10. Usual occupation OAA
11. Industry or business 30
MOTHER FATHER
12. Name Jacob Snyder
13. Birthplace (City, town, or county) Unknown (State or foreign country) 9
14. Maiden name Sarah Kinsey
15. Birthplace (City, town, or county) Unknown (State or foreign country) 9
16. (a) Informant M. Renard
(b) Address St. Louis City Hospital
17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof JAN 31 1948 (Month) (Day) (Year)
(c) Place: Anatomical Board burial or cremation
18. (a) Signature of funeral director Edward J. Cleveland
(b) Address 4104 MANCHESTER
19. (a) JAN 31 1948 (Date received local registrar) (b) J. F. Kenneck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 25th
year 1948 hour 3 minute 55 A.M.
21. I hereby certify that I attended the deceased from 1/15/48, 19..., to Jan 25th, 19 48
that I last saw him alive on Jan 25th, 19 48
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Respiratory failure
Due to Carcinomatosis
Primary site undetermined
Due to
Other conditions (Include pregnancy within 3 months of death) ascites
Syphilis undetermined
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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? 0
While at work? (Specify type of place) (e) Means of injury
23. Signature Rose E. Brown, M.D. (M.D. or other)
Address 1515 Lafayette Date signed 1/26/48

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

Jefferson City Printing Co.

(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.....

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.