

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21644
Registrar's No. 1468

FILED JUL 6 1948
Registration District No. 579

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Overland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 10872 Page 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 Tony Snodgrass
3. (b) If veteran, name war No 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Sarah Snodgrass 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased March 3 1874
(Month) (Day) (Year)

8. AGE: Years 74 Months 3 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Iron Mountain Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Machine Operator

11. Industry or business _____

MOTHER, FATHER { 12. Name Jessie Snodgrass
13. Birthplace Iron Mountain Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Samathia Strickland
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Martha Kaufmann
(b) Address Fredericktown, Mo.

17. (a) Burial (b) Date thereof 6-12-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fredericktown, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd
19. (a) 6-9-48 (b) Basile Sharp M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison 62
(c) City or town Fredericktown
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 9 year 1948 hour 9 minute 22 P.M.

21. I hereby certify that I attended the deceased from June 1st 1948 to June 9th 1948
that I last saw him alive on June 9th 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 2 yrs
Duration

Due to Chronic Nephritis 3 yrs

Due to 131
Other conditions Artemia
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
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 Arnold H. Winger (M. D. or other) M.D.
Address 8900 St. Charles Rd Date signed 6/11/48

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 *Gustav W Dietrich*
.....
..... : Licensed Embalmer No. *4329*
..... P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.