

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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 3289

490

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003- Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO	c. LENGTH OF STAY (in this place) 6 DAYS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 2507 1/2 MCNAIR	

3. NAME OF DECEASED (Type or Print) ORA		a. (First)	b. (Middle) -	c. (Last) SNYDER	4. DATE OF DEATH (Month) (Day) (Year) 1-17-49		
--	--	------------	---------------	------------------	--	--	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH MAR. 1, 1905	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months 10	IF UNDER 1 YEAR Days 16	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
---------------	------------------------	--	-------------------------------	------------------------------------	---------------------------	-------------------------	-----------------------	----------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ARKANSAS		12. CITIZEN OF WHAT COUNTRY?	
--	--	-----------------------------------	--	---	--	------------------------------	--

13a. FATHER'S NAME JOHN BROWNFIELD		13b. MOTHER'S MAIDEN NAME ROSE SCOTT		14. NAME OF HUSBAND OR WIFE CLAUDE SNYDER-2507 MCNAIR	
---------------------------------------	--	---	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS	
--	-------------------------	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pt lobar pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pt pyonephritis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 108907			INTERVAL BETWEEN ONSET AND DEATH 4 days ?
---	--	--	--	--	---

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from 1-10-49, 1949, to 1-17-49, 1949, that I last saw the deceased alive on 1-17-49, 1949, and that death occurred at 1 A.M., from the causes and on the date stated above.

23a. SIGNATURE E.H. Bowden M.D.	(Degree or title)	23b. ADDRESS 634 1/2 Grand	23c. DATE SIGNED 1-17-49
------------------------------------	-------------------	-------------------------------	-----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-20-49	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
---	----------------------	--	---

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 17 1949	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kuter	ADDRESS 2906 Gravois
--	--	--	-------------------------

SEP 25 1952

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Leo J. Budd  
Licensed Embalmer No. 3989

P. O. Address St. Louis, 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.