

FILED MAR 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8623

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1030

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Overland Park</u>	
c. LENGTH OF STAY (in this place) <u>18 days</u>		d. STREET ADDRESS (If rural, give location) <u>5241 West 75th Street 2-</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Trinity Lutheran Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>FREDERICK</u> b. (Middle) <u>CREED</u> c. (Last) <u>SNYDER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 4 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>February 12, 1869</u>
9. AGE (In years last birthday) <u>80</u>		10. AGE (In years last birthday) <u>80</u> 11. AGE (In years last birthday) <u>80</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor (Retired Commerce Trust Co.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auditing & Analysis</u>	
11. BIRTHPLACE (State or foreign country) <u>Cass County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>HENRY CLAY SNYDER</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH JANE CREED</u>	
14. NAME OF HUSBAND OR WIFE <u>JOHNNIE R. SNYDER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1174 EAST 27th STREET KANSAS CITY, MO</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>MRS. FREDA TURNER</u>		ADDRESS <u>1174 EAST 27th STREET KANSAS CITY, MO</u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Dissecting Aneurysm of the Abdominal aorta (n.s.)</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>451X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES ☐ NO ☐			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-15</u> , 19 <u>48</u> , to <u>3-4</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>3-3</u> , 19 <u>49</u> , and that death occurred at <u>5:05A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Doyle C. Whitman</u> (Degree or title) <u>M.D.</u>		23b. ADDRESS <u>1003 Sharp Bldg K.C.</u>	
23c. DATE SIGNED <u>3-4-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24b. DATE <u>MAR-6-1949</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>D.W. NEWCOMER'S SONS</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>3-5-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>D.W. Newcomer's Sons</u>		ADDRESS <u>1401 BRUSH CREEK BLVD KANSAS CITY, MISSOURI</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Signed _____

Edward M. Stone

Signed _____

Student Embalmer

Licensed Embalmer No. *4452*

P. O. Address *K. C. 4 M*

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.