

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43342

State File No. 1423  
Registrar's No. 11423

FILED JAN 10 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY <b>213</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4223 Gibson Ave.</b>		d. STREET ADDRESS (If rural, give location) <b>4223 Gibson Ave.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>CHARLES</b> b. (Middle) <b>W.</b> c. (Last) <b>SNELSON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 23 1951</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Jan. 5, 1917</b>		9. AGE (In years last birthday) <b>34</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman-Tower Grove Foundry Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>St. James, Mo. D</b>		12. CITIZEN OF WHAT COUNTRY?			

13a. FATHER'S NAME <b>Frank Snelson</b>		13b. MOTHER'S MAIDEN NAME <b>Ava Swyers</b>		14. NAME OF HUSBAND OR WIFE <b>Lucy Snelson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Lucy Snelson 4223 Gibson Ave.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Sarcoma of Bone (Pelvis)</b>		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				?	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<b>Metastases to Lung</b>				<b>Nov 1 - 1951</b>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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? <b>196K</b>	

22. I hereby certify that I attended the deceased from **Nov 12, 1951**, to **Dec 22, 1951**, that I last saw the deceased alive on **Dec 22, 1951**, and that death occurred at **9:15 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>H. G. Moore M.D.</b> (Degree or title)		23b. ADDRESS <b>917 - 5018</b>		23c. DATE SIGNED <b>12-24-51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal (Mtr)</b>		24b. DATE <b>12-25-51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. James, Mo.</b>					

DATE REC'D BY LOCAL REG. <b>DEC 24 1951</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauer 4228 S. Kingshighway Bl.</b>	
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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.....

.....  
working under my personal supervision.

Signed.....  
Student Embalmer

Student Embalmer No.....  
Signed *Edwin M. Herriott*.....

Licensed Embalmer No. *3024*.....

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.**