

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8029

S. No. 300  
v. 10-48

FILED FEB 25 1953

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1245**

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>  c. LENGTH OF STAY (in this place) _____  d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____  c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>  d. STREET ADDRESS (If rural, give location) <b>4103 Tesson</b>	
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<b>3. NAME OF DECEASED</b> (Type or Print) <b>Freida Vandegriffe</b>	a. (First) _____ b. (Middle) _____ c. (Last) _____	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Feb. 1, 1953</b>
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<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>July 13, 1911</b>	<b>9. AGE</b> (In years last birthday) <b>41</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Leather Sole Dep't, Brown Shoe Co.</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Brown Shoe Co.</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Lesterville, Mo.</b>
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<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	<b>13a. FATHER'S NAME</b> <b>Charles Snodgrass</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Fronia Sherrill</b>
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<b>14. NAME OF HUSBAND OR WIFE</b> <b>Leonard</b>	<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>
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<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Leonard Vandegriffe, 4103 Tesson</b>	<b>ADDRESS</b> <b>4103 Tesson</b>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)	<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) _____  ANTECEDENT CAUSES _____ DUE TO (b) <b>Cerebral Apoplexy</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (c) _____	<b>INTERVAL BETWEEN ONSET AND DEATH</b>   _____
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.		

<b>19a. DATE OF OPERATION</b> _____	<b>19b. MAJOR FINDINGS OF OPERATION</b> _____	<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> _____
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <b>334X</b>
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**22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.**

<b>22a. SIGNATURE</b> <b>Catriel E Taylor, Coroner</b>	<b>22b. ADDRESS</b> <b>1500 Clark</b>	<b>22c. DATE SIGNED</b> <b>2-2-53</b>
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<b>24a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	<b>24b. DATE</b> <b>2-3-53</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>City</b>	<b>24d. LOCATION (City, town, or county) (State)</b> <b>Owensville, Mo.</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>FEB 2 1953</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Carl Smith MD</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Albert H. Hoppe</b>
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ADDRESS **4700 Washington Blvd**  
 (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.

Student .....  
Student Embalmer

Signed Robert M Murray

Licensed Embalmer No. 3749

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.