

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038237

STATE FILE NUMBER
10456

FILED NOV 10 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10456

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Jefferson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Mt. Vernon	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 809 Oakland	
3. NAME OF DECEASED (Type or print) First STYRL Middle VERNER Last SNYDER		4. DATE OF DEATH Month OCTOBER Day 30 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 23, 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Baraboo, Wisconsin
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME C. M. Snyder	
13b. MOTHER'S MAIDEN NAME Pearl Dieter		14. NAME OF HUSBAND OR WIFE Ardath Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. 11		16. SOCIAL SECURITY NO. 355-03-1117	17. INFORMANT Address Ardath Snyder, Mt. Vernon, Illinois.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTERATRIAL SEPTAL DEFECT (OSTIUM SECUNDUM) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) CONGENITAL HEART DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 7543			INTERVAL BETWEEN ONSET AND DEATH 41 YEARS
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from OCT. 27, 1958 to OCT. 30, 1958 and last saw her alive on OCT. 30, 1958 Death occurred at 12:00 NOON m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. E. Vermillion, M. D.		22b. ADDRESS BARNES HOSPITAL	
22c. DATE SIGNED 10/30/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-30-58	23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	23d. LOCATION (City, town, or country) (State) Streator, Illinois.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. OCT 31 1958	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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
Signature of Student Embalmer

Signed *Lawrence O. Berlin*

Licensed Embalmer No. *4979*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.