Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042284
STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11610

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: SAINT LOUIS — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST.LOUIS CITY HOSP.#I — Length of stay in 1b: 2/29

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 919a N.Kingshighway — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First THOMAS Middle RALPH Last SNYDER

4. DATE OF DEATH: Month NOVEMBER Day 30 Year 1958

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 17,1906
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Emerson Electric
11. BIRTHPLACE (City and state or country): Deadwood,S.Dakota
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Peter Snyder
13b. MOTHER'S MAIDEN NAME: Unknown Smith
14. NAME OF HUSBAND OR WIFE: Katherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Katherine Snyder, 919a So.Kingshighway — Address

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Tuberculous meningitis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Pulmonary Tuberculosis
DUE TO (c) 002X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 11/25/1958, to 11/30/1958 and last saw her/him alive on 11/30/1958
Death occurred at 2.40 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: David J. Johnson MD (Degree or title)
22b. ADDRESS: 1515 LAFAYETTE AVE.
22c. DATE SIGNED: 11/30/1958

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-4-58
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis,Mo.

24. FUNERAL DIRECTOR: Albert H. Hoppe — ADDRESS: 4700 Washington, Blvd.
25. DATE RECD. BY LOCAL REG.: DEC 2 '58
26. REGISTRAR'S SIGNATURE: J. Earl Smith MD (H.T.)

(Licensed Embalmer's Statement on Reverse Side)

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 G. W. Wilkinson

Licensed Embalmer No. 357

P. O. Address St. Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.