

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044485

FILED VS NOV 28 1960

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 3352

STATE FILE NUMBER

UNDED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves</u>		Length of stay in 1b <u>YAS.</u>		c. CITY OR TOWN <u>Webster Groves</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>833 Atalanta Ave.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>833 Atalanta Ave.</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARENCE TODD SNYDER</u>				4. DATE OF DEATH Month Day Year <u>Nov. 17, 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8/19/1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veterinary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt-Meat Insp.</u>		11. BIRTHPLACE (City and state or country) <u>Fayette, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Madison Snyder</u>			13b. MOTHER'S MAIDEN NAME <u>(unk) Swearington</u>		14. NAME OF HUSBAND OR WIFE <u>Lucy M. Snyder</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-34-7497</u>		17. INFORMANT Address <u>Cornith, Miss. Charles Snyder, 1408 Pincrest Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerosis Gen</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 <u>3-24-58</u> to <u>11-16-60</u> and last saw ^{her} _{him} alive on <u>11-16-60</u> Death occurred at <u>4:00 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Paul C. Drost, Jr.</u>				22b. ADDRESS <u>227 E. Lockwood</u>		22c. DATE SIGNED <u>11-18-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11/19/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Fayette, Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Parker-Aldrich, Webster Groves, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-18-60</u>		26. REGISTRAR'S SIGNATURE <u>John G. Mumflay, M.D.</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Leslie Welch

Licensed Embalmer No. 439

P. O. Address Bellevue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.