

OUR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042913

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11420** STATE FILE NUMBER

AMENDED

FILED DEC 12 1961

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 6-days		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3109 Cherokee St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Peter Snell				4. DATE OF DEATH Month Day Year Dec. 6, 1961				
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 4/5/71	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired) Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Amer. Car & Fdry.		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME ----- Snell			13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Minnie Jorns Snell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				17. INFORMANT Address Mrs. Minnie Snell-3109 Cherokee St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 3 or 4 years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Left Ventricular Cardiac Hypertrophy				3 or 4 years		
		DUE TO (c) Arteriosclerosis - Generalized				3 or 4 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) none					PART III. If deceased was female was there a pregnancy in last 90 days. 4200 <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.) 4200				
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 10/20/66 to 12/6/61 and last saw him her alive on 12/5/61 Death occurred at 6:20 A. m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Dr. Paul H. Helbert M.D.				22b. ADDRESS 2905 Cherokee St. St. Louis 18 Mo.		22c. DATE SIGNED 12/6/61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Dec. 8, 1961	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)		
24. FUNERAL DIRECTOR ADDRESS WACKER-HELDLERLE-3634 Gravois Ave.				25. DATE RECD. BY LOCAL REG. DEC 7 1961		26. REGISTRAR'S SIGNATURE Paul Smith M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 13 1978

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 Philip J. Krupin

Licensed Embalmer No. 3497

P. O. Address St. Louis

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.