

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046878

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11734**

STATE FILE NUMBER

FILED DEC 27 1961

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b. 15 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 Jewish Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 5983 Highland Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First ALBERT Middle Fox Last SNELL | 4. DATE OF DEATH Month 12 Day 14 Year 1961 |
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| 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 12-4-08 | 9. AGE (last birthday) 53 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Construction | 10b. KIND OF BUSINESS OR INDUSTRY Millner Elev. Co. | 11. BIRTHPLACE (City and state or country) St. Genevieve, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME Albert F. Snell | 13b. MOTHER'S MAIDEN NAME Henrietta | 14. NAME OF HUSBAND OR WIFE Dorothea R. Snell |
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| 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 Dorothea R. Snell, 5983 Highland |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEMORRHAGE FROM TEFLON AORTIC GRAFT 2 HR | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) ABSCESS ADJACENT TO GRAFT 2 wks | |
| | DUE TO (c) STATUS POST RESECTION OF AORTIC ANEURYSM + GRAFT REPLACEMENT | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 451X | 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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. | 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 |
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| 21. I attended the deceased from DEC 1, 1961 to DEC 14, 1961 and last saw her/him alive on DEC 14 1961 Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE (Degree or title) Walter D. Feris, M.D. | 22b. ADDRESS Jewish Hospital | 22c. DATE SIGNED 12/15/61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE 12-18-61 | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory | 23d. LOCATION (City, town, or county) (State) St. Louis County Mo. |
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| 24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral, 1905 Union Blvd. | 25. DATE RECD. BY LOCAL REG. DEC 18 1961 | 26. REGISTRAR'S SIGNATURE Lead Smith, M.D. |
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IF AMENDED

INSTEAD OF

SHOULD BE

FILE NO.

BY AFFIDAVIT OF POWER OF SITE: *Walter D. Feris, M.D.* MEDICAL CERTIFICATION

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 Warren A. Carver

Licensed Embalmer No. 3534

P. O. Address _____

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.