

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

11075-63-046065
STATE FILE NUMBER

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

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 22 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Moniteau	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis TOWN		c. CITY OR TOWN McGirk Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis in the Rock Hospitals, Inc.		d. STREET ADDRESS Box 63 (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Leonard Middle Thomas Last Snodgrass			4. DATE OF DEATH Month Nov. Day 8 Year 1963		
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 4-8-1897	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Penr. Signal Maintainer	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Booneville, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
---	--	--	--

13a. FATHER'S NAME Samuel J. Snodgrass	13b. MOTHER'S MAIDEN NAME Elizabeth Wilson	14. NAME OF HUSBAND OR WIFE Wife- Eula
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv.) yes W.W.I	16. SOCIAL SECURITY NO.	17. INFORMANT Address Eula Snodgrass, McGirk, Mo.
--	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) 420.1	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetic chronic Pulmonary		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 11-3-63 to 11-8-63 and last saw him ^{her} alive on 11/7/63 Death occurred at 3.45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE [Signature] (Degree or title) MD	22b. ADDRESS 1755 So Grand Ave.,	22c. DATE SIGNED 11/8/63
---	---	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-8-63	23c. NAME OF CEMETERY OR CREMATORY McGirk Cemetery	23d. LOCATION (City, town, or county) (State) McGirk, Mo.
---	-----------------------------	--	---

24. FUNERAL DIRECTOR Hugh Williams Funeral Home ADDRESS California	25. DATE RECD. BY LOCAL REG. NOV 8 1963	26. REGISTRAR'S SIGNATURE [Signature]
---	---	---

Mo (Licensed Embalmer's Statement on Reverse Side)

VS 300
Rev. 4/59

1

2 **680-**

3

4 **0**

5 **1**

6

7 **0**

8 **2**

9

10

11

12 **69-0**

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

69

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 Stanley H. DeFou

Licensed Embalmer No. 4193

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.