

FILED OCT 31 1945

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days
(Specify whether Life)
In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 177
(d) Street No. 4828 Anderson
(If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24,
year 1945 hour 12:45 PM minute _____ M.
21. I hereby certify that I attended the deceased from Sept 23
1945 to Sept 24, 1945
that I last saw him alive on Sept 24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death. _____
Duration _____

Prematurity

Due to 5 1/2 mo gestation

Due to 159

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify type of place)
(e) Means of injury 0

23. Signature B. H. Linsman (M.D. or other) M.D.
Address 4126 E. Shaver Date signed 9/25/45

3. (a) PRINT FULL NAME

Infant Snyder
Baby Snyder

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sep 22 1945
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 2 hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name James Henry Snyder

13. Birthplace Rector Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Eaton

15. Birthplace Wells Maine
(City, town, or county) (State or foreign country)

16. (a) Informant Opie Miller

(b) Address 3310 Missouri

17. (a) Burial (b) Date thereof 9/25/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave

19. (a) SEP 25 1945 (Date received local registrar)
J. F. Bredeek (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed

L. R. Cooper

Licensed Embalmer No.

3633

P. O. Address

2317 Lafayette St

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