

No. 2
I-5-43
5-17-39
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UNITED STATES BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15663**
Registrar's No. **3786**

FILED APR 21 1947
318

Registration District No. _____ Primary Registration District No. **1002**

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:
2802 1/2 Cass Ave. 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community **30 YEARS**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **003**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **2802 1/2 Cass Ave. 1**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **JOHN SNIPES**

3. (b) If veteran, name war _____

3. (c) Social Security No. **494-056-233**

4. Sex **Male** 5. Color or race **NEGRA**

6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **EMMA S. SNIPES**

6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **3 10 1880**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67 0 25 hr. _____ min.

9. Birthplace **Ponce de Leon Florida**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Joe Snipes**

13. Birthplace **Florida**
(City, town, or county) (State or foreign country)

14. Maiden name **Julia Watson**

15. Birthplace **Florida**
(City, town, or county) (State or foreign country)

16. (a) Informant **EMMA SNIPES**

(b) Address **2802 1/2 Cass Ave. 1**

17. (a) **Burial** (b) Date thereof **4 11 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Dale**

18. (a) Signature of funeral director **Howell W. Co.**

(b) Address **7834 Gamble St.**

19. (a) **APR 10 1947** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **5**
year **1947** hour **12:20** minute **9** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Degeneration**

Due to _____

Due to _____

Other conditions **82**
(Include pregnancy within 9 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: Of operations _____

Of autopsy _____

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)

23. Signature **Arthur E. J. J. J.** (M. D. or other) **0**
Address _____ Date signed **4/11/47**

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 Chas. L. Howell

Licensed Embalmer No. 24520

P. O. Address. 2834 Bamble

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.