

FILED DEC 20 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

44250

STATE FILE NUMBER

Registration District No. 317Primary Registration District No. 547Registrar's No. 2905

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. PLACE OF DEATH  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |  |   |  |
| a. COUNTY<br><b>St. Louis</b>  |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Richmond Heights</b> |   | c. CITY OR TOWN<br><b>Maplewood</b>   |  | d. STREET ADDRESS<br><b>2625 Oakview Ter.</b>   |  |
| a. COUNTY<br><b>St. Louis</b>  |  | b. COUNTY<br><b>St. Louis</b>  |   | c. CITY OR TOWN<br><b>Maplewood</b>   |  | d. STREET ADDRESS<br><b>2625 Oakview Ter.</b>   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Richmond Heights</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |   | c. CITY OR TOWN<br><b>Maplewood</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br><b>St. Mary's Hosp.</b>   |  | Length of stay in 1b<br><b>9 days</b>  |   | d. STREET ADDRESS<br><b>2625 Oakview Ter.</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)  |  |  |   | 4. DATE OF DEATH  |  |   |  |
| First<br><b>ANN</b>  |  | Middle<br><b>ELIZABETH</b>   |   | Last<br><b>SNYDER</b>   |  | Month Day Year<br><b>Dec. 6th 1956.</b>   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Jan. 10 1894</b>   |  |
| 9. AGE (In years last birthday)<br><b>62</b>   |  | 10. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b>                                   |   | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>James Cochran</b>  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Hamilton</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |  |   | 16. SOCIAL SECURITY NO.<br><b>496-36-4410</b>   |  | 17. INFORMANT Address<br><b>John Snyder 2625 Oakview Ter.</b>                         |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Nephritis</b>  |  |  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |  | DUE TO (b) <b>Nephrosclerosis</b>  |   | 10 years  |  |   |  |
|  |  | DUE TO (c) <b>Arteriosclerosis</b>   |   | 10 years  |  | 446x  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes. Gangrene of left foot. Gangrenous areas both thighs.</b>   |  |  |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input 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.)<br><b>None</b> |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m.<br>p. m.<br><b>None</b>  |  |  | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)<br><b>None</b>    |   |  |   |  |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE<br><b>None</b>  |   |  |   |  |
| 21. I attended the deceased from <b>1930</b> to <b>Dec. 6, 1956</b> and last saw <del>him</del> <b>her</b> alive on <b>Dec. 6, 1956</b><br>Death occurred at <b>10:00 p. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated. |  |  |   |   |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>H. H. Webster, M.D.</b>   |  |  |   | 22b. ADDRESS<br><b>19 E. Lockwood Ave., Webster Groves 19, Mo.</b>  |  | 22c. DATE SIGNED<br><b>12-8-56</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 23b. DATE<br><b>Dec. 10 1956</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Calvary Cemetery</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b>                |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>A. H. Bocklage Fun. Home 6536 Clayton</b>   |  |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>12-9-56</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Herbert A. Donahue</b>                                |  |

USE ONLY BLACK INK OR RIBBON. TYPEWRITE IF POSSIBLE!

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 *Stanley H. Aida*.....

Licensed Embalmer No. *74*.....

P. O. Address *St. L.*.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.**  
- 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.