

Health, Welfare & Public Service

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

46351  
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11698**

300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Baptist Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>5064 Tholozan Ave.</b>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>F.</b> Last <b>SNYDER</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>3</b> Year <b>1957</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1884</b>	9. AGE (In years last birthday) <b>73</b>	10. FUNDER 1 YEAR	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (Retired) Hotel New Yorker</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Waukesha, Wisconsin</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Andrew Snyder</b>	13b. MOTHER'S MAIDEN NAME <b>Susan Stephen</b>	14. NAME OF HUSBAND OR WIFE <b>Ottillie Snyder</b>
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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) <b>No None</b>	16. SOCIAL SECURITY NO. <b>490-22-6412A</b>	17. INFORMANT Address <b>Ottillie Baier Snyder 5064 Tholozan</b>
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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) <b>Cardiac Arrest</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Anesthesia</b>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>610x</b>		

20a. ACCIDENT <input checked="" 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.) <b>While in aneurysm operation (pre state) at Missouri Baptist Hospital December 3rd 1957.</b>
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20c. TIME OF INJURY Hour <b>3</b> a.m. <b>12</b> p.m. <b>35</b> Month, Day, Year <b>December 3rd 1957.</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo.</b>	COUNTY	STATE
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hosp.</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo.</b>	COUNTY	STATE
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21. I attended the deceased from <b>1130 A.</b> to <b>1130 A.</b> and last saw her/him alive on <b>1130 A.</b> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>James M Kelly</b> (Degree or title) <b>Registrar</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>12-5-57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 6, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY. <b>S. Peter &amp; Paul Cem.</b>	23d. LOCATION (City, town, or country) (State) <b>St. Louis, Mo.</b>
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24. FUNERAL DIRECTOR <b>Kriegshauser 4228 S. Kingshighway</b>	25. DATE RECD. BY LOCAL REG. <b>DEC 5 57</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith MD</b>
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

mgs

**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 William S White .....

Licensed Embalmer No. 1291 .....

P. O. Address 428 1/2 E. 1st 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.