

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-007961  
STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 317 Primary Registration District No. 590 Registrar's No. 582

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis County, Mo.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b>		b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kinloch</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kinloch</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>454 Freeland Ave.</b>		Length of stay in lb <b>35 yrs.</b>		d. STREET ADDRESS (If outside, give location) <b>454 Freeland Ave.</b>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>Rev. Johnie G. Snider</b>			4. DATE OF DEATH Month Day Year <b>Feb. 28, 1959</b>		
---	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19, 1893</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	--	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (City and state or country) <b>Tuscaloosa, Alabama</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
--	--	--	---

13a. FATHER'S NAME <b>George Snider</b>	13b. MOTHER'S MAIDEN NAME <b>Georgiann Ball</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
--	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Mrs. Minnie J. Ligon 3141 School St.</b>
---	--	---

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>Hyperkine Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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>Malnutrition</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
--	--	---

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.) <b>443X</b>
---	---

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	---	--	--

21. I attended the deceased from <b>July 1958</b> to <b>Feb 18, 1959</b> and last saw him alive on <b>Feb 27, 1959</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the cause stated.
---

22a. SIGNATURE <b>L. M. Surran, M.D.</b> (Degree or title)	22b. ADDRESS <b>3861 St. Louis Ave.</b>	22c. DATE SIGNED <b>3-2-59</b>
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/5/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>
--	----------------------------	---	--

24. FUNERAL DIRECTOR <b>G. Wade Granberry 4202 Finney Ave.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>3-3-59</b>	26. REGISTRAR'S SIGNATURE <b>John C. Murphy, M.D.</b>
---	---------	---	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Edward A. Flynn* .....

Licensed Embalmer No. 4444 .....

P. O. Address 4202 Finney Ave. .....

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.