...RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS APR 22 1960

60-017930
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1,114

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Riverview
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 10022 Lilac D.
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Riverview
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 10022 Lilac Dr.
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Alfred Middle: John Last: Snyder
4. DATE OF DEATH Month: April Day: 2nd, Year: 1960
5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 3/16/91
9. AGE (last birthday) 69
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) St. Louis
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME A. Snyder
13b. MOTHER'S MAIDEN NAME Not Known
14. NAME OF HUSBAND OR WIFE # Clara Ann Snyder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 495-05-0138
17. INFORMANT Clara Ann Snyder Address 10022 Lilac Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage into the left pleural cavity
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cutting of the thyrocervical trunk of the left subclavian artery
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☒ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Self inflicted knife wound of the throat
20c. TIME OF INJURY 5:30 Hour a.m. ~~p.m.~~ Month, Day, Year 4/2/60
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) basement of home
20f. CITY, TOWN, OR LOCATION Riverview Gardens COUNTY St. Louis STATE Mo.
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

BY AFFIDAVIT OF

22a. SIGNATURE Raymond Hand (Degree or title) Coroner
22b. ADDRESS Clayton, Mo.
22c. DATE SIGNED 4/8/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4-5-60
23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR DIEDRICH FUNERAL HOME ADDRESS 8319 Hallsferry Rd.
25. DATE RECD. BY LOCAL REG. 4-4-60
26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
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.