

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004670

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042 Primary Registration District No. 1000 Registrar's No. 225

STATE FILE NUMBER

AMENDED

Registration District No. 042
FILED VS MAR 6 1961

1. PLACE OF DEATH a. COUNTY <u>Fuchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Fuchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>St. Joseph</u>	
Length of stay in lb <u>1 Yr.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Methodist Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>609 South 15th St.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lloyd</u> Middle <u>Earl</u> Last <u>Snyder</u>			4. DATE OF DEATH Month <u>February</u> Day <u>25</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1892</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give info of work done during most of working life, even if retired) <u>Elect. Maintenance man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Signal Corps</u>		11. BIRTHPLACE (City and state or country) <u>ear, Nebraska</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Ralph Melvin Snyder</u>			
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Shea</u>		14. NAME OF HUSBAND OR WIFE <u>Bess Chapman Snyder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W W 41</u>		17. ADDRESS <u>Mrs. Fern Snyder St. Joseph, Mo.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Failure of HEART</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
DUE TO (b) <u>Chronic glomerular Nephritis</u>		<u>"</u>
DUE TO (c) <u>Nephrotic Syndrome</u>		<u>"</u>

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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month _____ Day _____ Year _____
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 <u>St. Joseph</u>	COUNTY _____ STATE _____
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21. I attended the deceased from <u>1-31-61</u> to <u>2-25-61</u> and last saw ^{her} him alive on <u>2-25-61</u> Death occurred at <u>6:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) <u>Maxwell Day M.D.</u>	22b. ADDRESS <u>109 N 7th</u>	22c. DATE SIGNED <u>2-28-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Febr. 28, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph Mo.</u>
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24. FUNERAL DIRECTOR <u>Meierhoffer-Fleeman Inc.</u>	ADDRESS <u>St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Mar. 1, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>
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DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

M. Day, M.D.

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 Albert P. Harrington

Licensed Embalmer No. 2555

P. O. Address St. Joseph

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.