

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE 042

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511

-61-016597  
STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED MAY 22 1961

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| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>                                                            |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> COUNTY <b>Buchanan</b> |                                                                                                                                                     |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph</b>                    |  | Length of stay in 1b<br><b>Life</b>                                                                                                      | c. CITY OR TOWN <b>St. Joseph</b> Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Mo. Methodist Hosp.</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                                                     | d. STREET ADDRESS (If outside, give location)<br><b>2405 So. 4th St.</b> Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |

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|-----------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Henry</b> Middle <b>C.</b> Last <b>Snyder</b> |  |  | 4. DATE OF DEATH<br>Month <b>May</b> Day <b>14</b> Year <b>1961</b> |  |  |  |
|-----------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------|--|--|--|

|                       |                                  |                                                                                                                                                             |                                    |                                     |                                            |                                          |
|-----------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------|--------------------------------------------|------------------------------------------|
| 5. SEX<br><b>Male</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>6-16-01</b> | 9. AGE (last birthday)<br><b>59</b> | IF UNDER 1 YEAR<br>Months _____ Days _____ | IF UNDER 24 HR<br>Hours _____ Min. _____ |
|-----------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-------------------------------------|--------------------------------------------|------------------------------------------|

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

|                                           |                                                      |                                                     |
|-------------------------------------------|------------------------------------------------------|-----------------------------------------------------|
| 13a. FATHER'S NAME<br><b>Isaac Snyder</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Elizabeth Norris</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Denine Snyder</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. | 17. INFORMANT Address<br><b>Denine Snyder, 2405 So. 4th St.</b> |
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| 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>Acute alcoholism</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____                      |  |                                                  |

|                                                                                                                                                                                      |  |                                                                                                                                                                      |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Suicide attempt 5-11-61 Sacerated throat</b> |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                                                                   |                                                                                                           |                                                                                              |
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| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m. | Month, Day, Year<br>_____ |
|---------------------------------------------------|---------------------------|

|                                                                                                        |                                                                                          |                                           |
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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 COUNTY STATE |
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| 21. I attended the deceased from <b>5-11-61</b> to <b>5-14-61</b> and last saw him/her alive on <b>5-14-61</b><br>Death occurred at <b>6:15A</b> on the date stated above, and to the best of my knowledge, from the causes stated. |
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|                                                               |                                      |                                    |
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| 22a. SIGNATURE (Degree or title)<br><b>J.L. Wolstead M.D.</b> | 22b. ADDRESS<br><b>2003 Fredrick</b> | 22c. DATE SIGNED<br><b>5-17-61</b> |
|---------------------------------------------------------------|--------------------------------------|------------------------------------|

|                                                            |                             |                                                               |                                                                              |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>5-16-61</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ashland Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Joseph, Missouri</b> |
|------------------------------------------------------------|-----------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------|

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| 24. FUNERAL DIRECTOR ADDRESS<br><b>John E. Rupp St. Joseph, Mo.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>May 19, 1961</b> | 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Clark Goodell</b> |
|---------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------|

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

BY AFFIDAVIT OF J.L. Mothershead, 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 John B. Pupp

Licensed Embalmer No. 3986

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.