

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-046879

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12103 STATE FILE NUMBER

FILED JAN 5 1962

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>St. Louis</u>                   |  | c. CITY OR TOWN <u>St. Louis</u>  |  |
| Length of stay in 1b<br><u>10 yrs.</u>  |  | 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 <u>Homer G. Phillips</u> |  | d. STREET ADDRESS (if outside, give location)<br><u>4667 Evans</u>  |  |
| Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                    |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                       |  |

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br>First <u>Floyd</u> Middle <u>Snelson</u> Last                                |                                  |   | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>23</u> Year <u>61</u>    |  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Negro</u> | 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><u>MAY 7 1892</u>                               | 9. AGE (last birthday)<br><u>69</u>                  | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSE WIFE</u>    |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>NONE</u>  | 11. BIRTHPLACE (City and state or country)<br><u>Lexington MISS</u> | 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A</u>          |   |
| 13a. FATHER'S NAME<br><u>MARVIN MONTGOMERY</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>LIMMIE DICKERSON</u>  |   | 14. NAME OF HUSBAND OR WIFE<br><u>JAMMIE Snelson</u> |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u> |                                  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  | 17. INFORMANT<br><u>Leedoshia Hudson 4667<sup>a</sup> EVANS</u>     |  |   |

|   |  |   |
|---|--|---|
| 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) <u>Bronchopneumonia</u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Undet.</u>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____                      |  | <u>491x</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.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

|  |   |  |   |
|--|---|--|---|
| 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.) |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____  |   |  |   |
| 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 _____  |
| 21. I attended the deceased from <u>12-11-61</u> to <u>12-23-61</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>12-23-61</u><br>Death occurred at <u>4:08</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |
| 22a. SIGNATURE<br><u>Chas. A. Fordy M.D.</u> (Degree or title)   |   | 22b. ADDRESS<br><u>2601 N. Whittier Street</u>   | 22c. DATE SIGNED<br><u>12-26-61</u>                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>REMOVAL</u>  | 23b. DATE<br><u>12-28-61</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>GREENWOOD Cemetery</u>                              | 23d. LOCATION (City, town, or county) (State)<br><u>ST LOUIS (149) MO</u> |
| 24. FUNERAL DIRECTOR<br><u>PRICE AND COONE</u>   | ADDRESS<br><u>2829 Washington</u>   | 25. DATE RECD. BY LOCAL REG.<br><u>DEC 26 1961</u>   | 26. REGISTRAR'S SIGNATURE<br><u>Loan Smith M.D.</u>                       |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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.