

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

2058

-62-008768

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED FEB 28 1962

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |   |
| a. COUNTY - - -   |   | a. STATE <b>Mo.</b> b. COUNTY - - -   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis, Missouri</b>   |   | c. CITY OR TOWN <b>St. Louis, Missouri</b>  |   |
| Length of stay in lb <b>3 days</b>  |   | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <del>XXXXXXXXXX</del> <b>DePaul Hospital</b>                                      |   | d. STREET ADDRESS (If outside, give location) <b>5228 Alabama</b>   |   |
| 3. NAME OF DECEASED (Type or print)   |   | 4. DATE OF DEATH  |   |
| First <b>Carolyn</b> Middle <b>M.</b> Last <b>Snyder</b>  |   | Month <b>February</b> Day <b>18,</b> Year <b>1962</b>   |   |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b>   | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>                     | 8. DATE OF BIRTH <b>9-22-1900</b>                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Registered Nurse (Ret.)</b>                                 |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Medical Profession</b>  | 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b> |
| 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   | 13. FATHER'S NAME <b>Josphe F. Snyder</b>   |   |
| 14. MOTHER'S MAIDEN NAME <b>Anna M. Schmitz</b>   |   | 15. NAME OF HUSBAND OR WIFE <b>- - -</b>  |   |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 17. SOCIAL SECURITY NO. <b>None</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |   | 19. INFORMANT <b>Miss Ann Snyder</b> Address <b>5228 Alabama</b>  |   |
| IMMEDIATE CAUSE (a) <b>Cardiac insufficiency</b>  |   | INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>   |   |
| DUE TO (b) <b>Rheumatic heart disease</b>   |   | <b>4 years</b>  |   |
| DUE TO (c) <b>4/6x</b>  |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Pulmonary infarct</b> |   | 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 |   |
| 20. TIME OF INJURY  | 21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      | 22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |   |
| Hour _____ a.m. _____ p.m.  | 23. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> |   |   |
| Month, Day, Year _____  | 24. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>               | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
|   | 26. CITY, TOWN, OR LOCATION _____   | COUNTY _____ STATE _____  |   |
| 27. I attended the deceased from <b>March 23, 1959</b> to <b>February 18, 1962</b> and last saw her alive on <b>February 18, 1962</b>                         |   | 28. Death occurred at <b>520 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |
| 29. SIGNATURE (Degree or title)<br><b>John T. Lewtan, M.A.</b>  |   | 30. ADDRESS <b>634 N. Grand Blvd.</b>   |   |
| 31. DATE <b>2-22-62</b>   |   | 32. DATE SIGNED <b>Feb. 20, 1962</b>  |   |
| 33. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul</b>   |   | 34. LOCATION (City, town, or county) <b>St. Louis, Missouri</b>   |   |
| 35. FUNERAL DIRECTOR <b>HOFFMEISTER COLONIAL MORTUARY</b> ADDRESS <b>SAM</b>  |   | 36. DATE RECD. BY LOCAL REG. <b>FEB 20 1962</b>   |   |
| 37. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>   |   |   |   |

Dr. John T. Lawton  
Mo. Theatre Bldg.  
634 N. Grand Blvd.  
JE. 3-3076

### 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 *Rich C. Hanson*

Licensed Embalmer No. 4764

P. O. Address St Louis Mo

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.