

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

67 0011599
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 6073 Registrar's No. 115

FILED APR 11 1967

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 0940
2 0940
3
4 0
5 1
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8 2
95020
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12 90-0
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

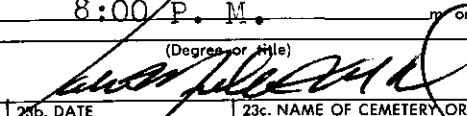

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. FRANCOIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>R.F.D.I. BONNE TERVE.</u>		c. CITY OR TOWN <u>R.F.D.I. BONNE TERVE.</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>AT HOME PERRY Twp.</u>		d. STREET ADDRESS (If outside, give location) <u>R.F.D.I. BONNE TERVE.</u>	
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN CALVIN SNYDER</u>			4. DATE OF DEATH Month Day Year <u>MARCH 26 1967</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 29, 1896</u>
9. AGE (last birthday) <u>71</u>		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) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>	11. BIRTHPLACE (City and state or country) <u>BONNE TERVE - MO?</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>JOHN H. SNYDER</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH VANDIVER.</u>	
14. NAME OF HUSBAND OR WIFE <u>MARY ROLENS.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <u>YES</u> (known) (If yes, give war or dates of service) <u>W.W.I.</u>)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS MARY ROLENS. R.F.D.I. - BONNE TERVE.</u>		Address	
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>Chronic bronchitis</u> DUE TO (b) <u>Pulmonary emphysema</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis.</u>			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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Hour a.m. p.m. 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>8-15-66</u> , to <u>3-15-67</u> and last saw ^{her} him alive on <u>3-15-67</u> Death occurred at <u>8:00 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) 		22b. ADDRESS <u>Bonne Terre, Missouri</u>	
22c. DATE SIGNED <u>3-31-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3-28-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MARVIN CHAPEL CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>R.F.D.I. BONNE TERVE - MO.</u>	
24. FUNERAL DIRECTOR <u>CALDWELL & SONS</u>		25. DATE RECD. BY LOCAL REG. <u>Apr 3, 1967</u>	
ADDRESS <u>FLAT RIVER - MO.</u>		26. REGISTRAR'S SIGNATURE 	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

APR 12 1967

APR 20 1967

APR 24 1967

Burial Permis issued 3-31-67

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 David P. Caldwell

Licensed Embalmer No. 5184

P. O. Address Flat River, 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.