WRITE PLAINLY, WITH UNFADING INK—THIS IS A PE

N. B.—Every item of information should be carefully supplied. AGE should be stated EX
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statemen

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Pemiscot

Township or Village or City: Steele

Registration District No. 655 — File No. 27093

Primary Registration District No. 4392 — Registered No. 21

(NO. ____ St.; ____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Tillman Snow Jr

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH: March 16th (Month) (Day), 1911 (Year)

AGE: 1 yrs. 4 mos. 11 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): X

BIRTHPLACE (City or town, State or foreign country): Steele, Missouri

PARENTS
- NAME OF FATHER: Tillman Snow
- BIRTHPLACE OF FATHER (City or town, State or foreign country): Tennessee
- MAIDEN NAME OF MOTHER: Ellen Matthews
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tennessee

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tillman Snow X

(ADDRESS) Steele, Mo

Filed Aug 26th 1912 H E Dorner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: August 25th (Month) (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 18th, 1912, to Aug 24th, 1912, that I last saw him alive on August 24th, 1912, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

58 Malarial fever

(Duration) ___ yrs. 8 mos. 8 ds.

Contributory (SECONDARY) ___ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J W Robbins M. D.

Aug 26th 1912 (Address) Steele, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State: ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? ___

Former or usual residence ___

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetary	Aug 26th 1912
UNDERTAKER	ADDRESS
Steele Supply Co	Steele Mo

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

N.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward) [If death in hospital give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____ (Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____, 191____ (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS