LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH
County Dallas
Township N Benton
or
Village
or
City (NO. St.; Ward)

Registration District No. 241 File No. 33820-B
Primary Registration District No. 5334 Registered No.

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

2 FULL NAME Flora Idella Snider

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: (Month) (Day) 1 (Year)

7 AGE: 61 yrs. 3 mos. 3 ds.
If LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country): Mo.

PARENTS
10 NAME OF FATHER: Goss
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. D. Snider
(Address) Buffalo Mo

15
Filed 191 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 11 (Month) 12 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 5 - 1920, to Nov 12 - 1920, that I last saw h[illegible] alive on Nov 8 - 1920, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Valvular heart Lesion
926

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) G. L. McGuyer M. D.
Nov 14 1920 (Address) Buffalo Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Reynolds
DATE OF BURIAL: 11-14 1920
20 UNDERTAKER: Jack Kuyendall
ADDRESS: Buffalo Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 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 occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address).....

15

Filed..... ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

17 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.

18 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.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.