

APR 27 1927

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

Do not use this space.

8973

1. PLACE OF DEATH

County *Miss*  
Township *W. Waplesburg*  
City (No. ....) St. .... Ward)

Registration District No. *566*  
Primary Registration District No. *5762*

File No. ....  
Registered No. *20*

2. FULL NAME *Eula Sneed*

(a) Residence No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *Black* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 22 1926*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*11 13*

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Baby*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN; STATE OR COUNTRY) *Miss County Mo*

10. NAME OF FATHER *Amos Sneed*

11. BIRTHPLACE OF FATHER (CITY OR TOWN; STATE OR COUNTRY) *Lee Co Ark*

12. MAIDEN NAME OF MOTHER *Catherine Jones*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN; STATE OR COUNTRY) *Lee Co Ark*

14. INFORMANT *Amos Sneed*  
(Address) *Charleston Mo*

15. *Mar 9<sup>th</sup> 1927 J. S. Vernon*  
FILED REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March 9<sup>th</sup> 1927*

17. *did not have doctor*  
I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....  
that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at *8:30 a.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Pneumonia*  
*107 A 89 A*  
*Access in ear*  
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS? *Family history*  
(Signed) *Frank S. Vernon*, M. D.  
Address *Charleston Mo*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Cook Grove* DATE OF BURIAL *3-9-1927*

20. UNDERTAKER *Private* 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.

PARENTS

