

JUN 27 1927

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

Do not use this space.

14778

1. PLACE OF DEATH

County Green
Township Springfield
City Springfield

Registration District No. 318
Primary Registration District No. 2001

File No. _____
Registered No. 288
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1927 N. Main St. _____
(Usual place of abode) _____

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Maggie Snodgrass

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Feb 19-1847

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>80</u>	<u>2</u>	<u>17</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer
(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)

N. Virginia

PARENTS

10. NAME OF FATHER

Nathan Snodgrass

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Unknown

14.

INFORMANT Mrs. Maggie Snodgrass
(Address) Springfield, Mo.

15.

FILED 5/10 27 Dr. Horst Med.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-8-1927

17. I HEREBY CERTIFY, That I attended deceased from Apr. 9, 1927, to May 8, 1927. I last saw him alive on Apr. 27, 1927 and that death occurred, on the date stated above, at 12 noon.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis
IB
931

(duration) yrs. 1 mos. 15 ds.
CONTRIBUTORY (SECONDARY) Influenza
(duration) yrs. _____ mos. 1 ds.

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH

DID OPERATOR PREVENT DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. E. Zeller, M. D.

5-10-1927 (Address) Springfield, 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

DATE OF BURIAL

Green Lawn Cemetery May 10 1927

20. UNDERTAKER

ADDRESS

W. Klingner & Co. 47 Springfield, Mo.

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.

