R 19 1928

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

Do not use this space.

4660

1. PLACE OF DEATH: County Greene; Township N Jackson; City Fairgrove (No. ... St. ... Ward); Registration District No. 219; Primary Registration District No. 5447A; File No. 5; Registered No. 5

2. FULL NAME George W. Snider

(a) Residence. No. ... St. Fair Grove Mo. 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. ... ds. How long in U.S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED: HUSBAND OF (OR) WIFE OF Elizabeth Jane Snider

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 17-1853

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
	75	0	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: 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) Mo.

PARENTS

10. NAME OF FATHER Alex Snider
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ... (STATE OR COUNTRY) N. Carolina
12. MAIDEN NAME OF MOTHER Polly Wommack
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ... (STATE OR COUNTRY) Unknown

14. INFORMANT Lee Snider
(Address) Springfield Mo.

15. FILED Feb 20, 19... John L. Klingner REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 17 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1928, to Feb 17, 1928, that I last saw h... alive on Feb 5, 1928, and that death occurred, on the date stated above, at 3 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Pareisis
89
87B
(duration) about 3 yrs ... mos. ... ds.

CONTRIBUTORY (SECONDARY) ...
(duration) ... yrs. ... mos. ... ds.

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

D DID AN OPERATION PRECEDE DEATH? no DATE OF ~
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W. Wm A Cowden, M.D
Feb 19 1928 (Address) 200 S Connecticut St

*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
Cedar Bluff Cemetery	Feb 15 1928

20. UNDERTAKER J. W. Klingner & Son ADDRESS 424 E. Commercial St 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH. Greene
County Greene Registration District No. 322 File No.
Township N. Jackson Primary Registration District No. 5447 Registered No.
City (No. , St. Ward)

2. FULL NAME George W Snider
(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M.	W.	M.

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

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

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

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

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED Dec 1 P. 1928 T. Obie Klingman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14 1928

17. 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 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Generalized Paresis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Pary lasis Agitans
(duration) about Four years mos. ds.

18. WHERE WAS DISEASE CONTRACTED 96
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*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 19
20. UNDERTAKER T. W. Klingman	ADDRESS Springfield Mo

SUPPLEMENTARY

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW