

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

Do not use this space.

1. PLACE OF DEATH

County Shelby
Township Jackson
City Jackson (No.)

Registration District No. 828
Primary Registration District No. 643-60

File No. 26137
Registered No. ✓
St. Ward)

2. FULL NAME

Mrs. Elizabeth 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May-29-1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or min.
71 1 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic
(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) Missouri

10. NAME OF FATHER

Samuel Calama

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ky.

12. MAIDEN NAME OF MOTHER

Mary Lewis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ky.

14. INFORMANT

(Address) Ellie Pearl Turner
Taboran Mo

15. FILED

7/6 1928 R.H. Parker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5 19 28

17. I HEREBY CERTIFY That I attended deceased from June 1927 to July 5 1928
that I last saw h. alive on June 29 19 28, and that death occurred, on the date stated above, at 3 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

hemiplegia

CONTRIBUTORY (SECONDARY)

750

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) W.J. Smith, M.D.
, 19 (Address) Shelby 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

Oakdale Cemetery

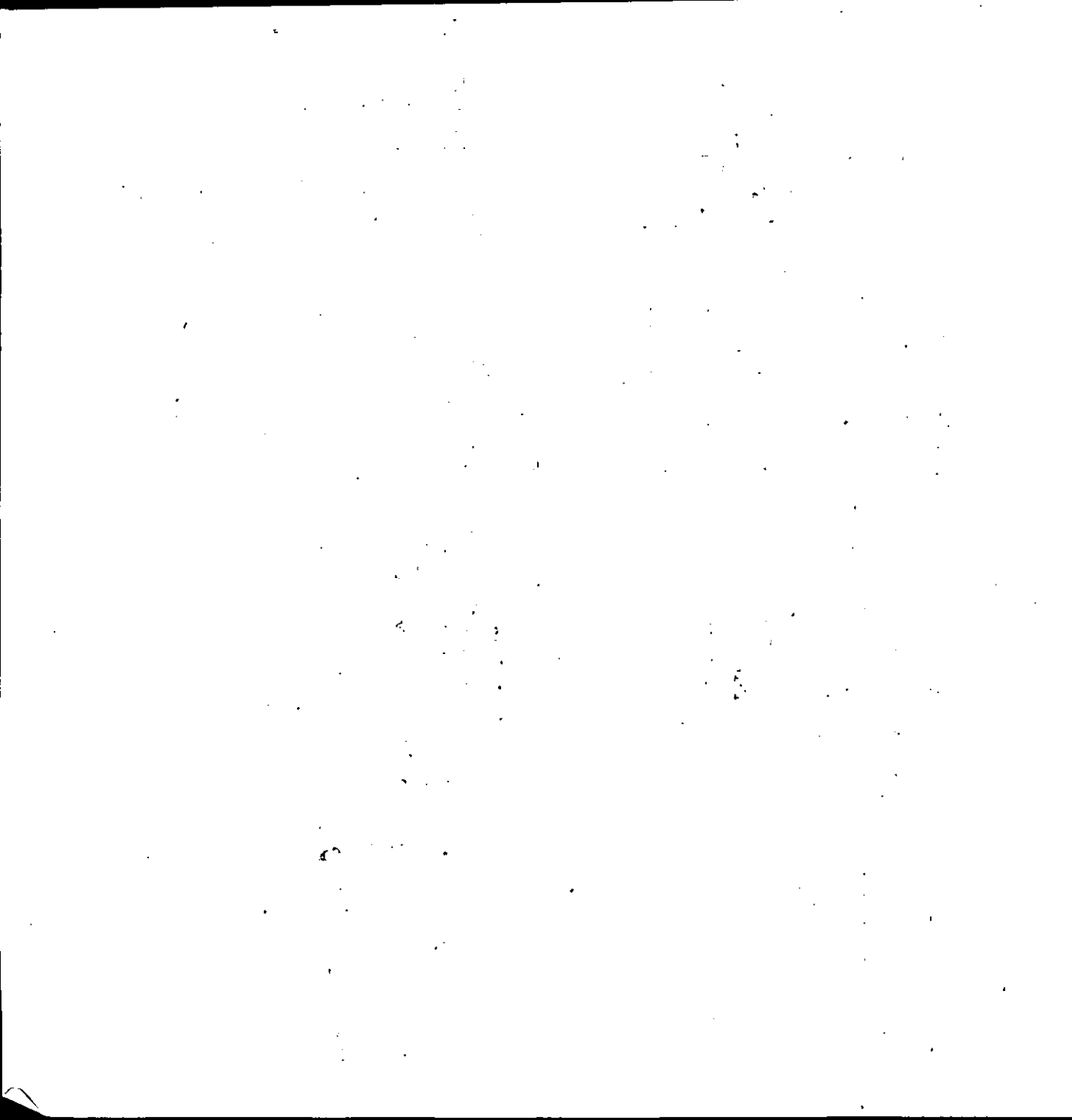
7/7 1928

20. UNDERTAKER

ADDRESS

Glover L. Livan

Hummer



**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.

County Shelby
Township Jackson
City _____ (No. _____)

Registration District No. 828
Primary Registration District No. 6040

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

2. FULL NAME

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 29-1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 1 6

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)

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 19 RA Parker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 5-1928

17. I HEREBY CERTIFY, That I attended deceased from July 5-1928, to July 5-1928, that I last saw him alive on July 5-1928, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: (duration) yrs. mos. da.

DID AN OPERATION PRECEDE DEATH: DATE OF

WAS THERE AN AUTOPSY: (duration) yrs. mos. da.

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

20. UNDERTAKER ADDRESS

5-26137