

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

Do not use this space.

42149

JAN 28 1929

1. PLACE OF DEATH

County Randolph Registration District No. 735 File No. _____
 Township Moberly Primary Registration District No. 3034 Registered No. 229
 City Moberly (No. 809 No Moberly) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 809 No Moberly 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14th 1849

7. AGE YEARS MONTHS DAYS H LESS than 1 day, _____ hrs. or _____ min.
78 9 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
 (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) Pa

10. NAME OF FATHER Charles Sneider

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

12. MAIDEN NAME OF MOTHER May Suddith

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

14. INFORMANT Mrs Walter Bunn (Address) Moberly, Mo

15. FILED 12/8 28 1928 D. Tho. J. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 6th 1928

17. I HEREBY CERTIFY That I attended deceased from Oct 27-1928 to Dec 5-1928 that I last saw her alive on Dec 5-1928, and that death occurred, on the date stated above, at 12:30 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Myocarditis
9013 75 (duration) 2 yrs. - mos. - da.

CONTRIBUTORY (SECONDARY) Arterio-sclerosis (duration) 10 yrs. - mos. - da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. at place of death.

DID AN OPERATION PRECEDE DEATH. No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms. (Signed) E. V. Spradler, M. D.

12-8, 1928 (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 Phillips Chapel DATE OF BURIAL 12-8-1928

20. UNDERTAKER Mahon and Son ADDRESS Moberly, Mo

79-9-22

Every 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

County Paradolph Registration District No. 435- File No.
Township Primary Registration District No. 3034 Registered No. 229
City Moberly 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 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) Feb 14 - 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
79 9 22

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 12/8 1928 Dr. Tho. S. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 6 1928

17. I HEREBY CERTIFY That I attended deceased from
..... 19.....
(that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above).....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

MONTHLY (PRIMARY)
(SECONDARY)

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)....., 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 ADDRESS

SUPPLEMENTARY

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

CAUSE OF DEATH in plain terms. It may be properly claimed. Exact statement of OCCUPATION is very important.

S-42149