

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

Do not use this space.

30202

21929

1. PLACE OF DEATH

County Butler

Registration District No. 89

File No. _____

Township _____

Primary Registration District No. 3007

Registered No. 156

City Poplar Bluff (No. _____)

St. _____ Ward _____

2. FULL NAME

James M. 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 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 Victoria Snider

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 16 - 1896

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 10 5

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) Retired
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER William Snider

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

12. MAIDEN NAME OF MOTHER Leta Snider

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

14. INFORMANT Arnet Snider
(Address) Springfield Mo

15. Sept 21-29 1929 Dr B J Clump
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1929

I HEREBY CERTIFY, That I attended deceased from Sept - 17 1929 to Sept - 21 1929, that I last saw him alive on Sept - 11 1929, and that death occurred, on the date stated above, at 11 - A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Hypo-static Pneumonia
21/29
11/29 (duration) yrs. mos. ds. 2
CONTRIBUTORY (SECONDARY) Fracture Tibia (Left Leg)
(duration) yrs. mos. ds. 2

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W H Stanford M. D.
Sept 22, 1929 (Address) Poplar Bluff Mo

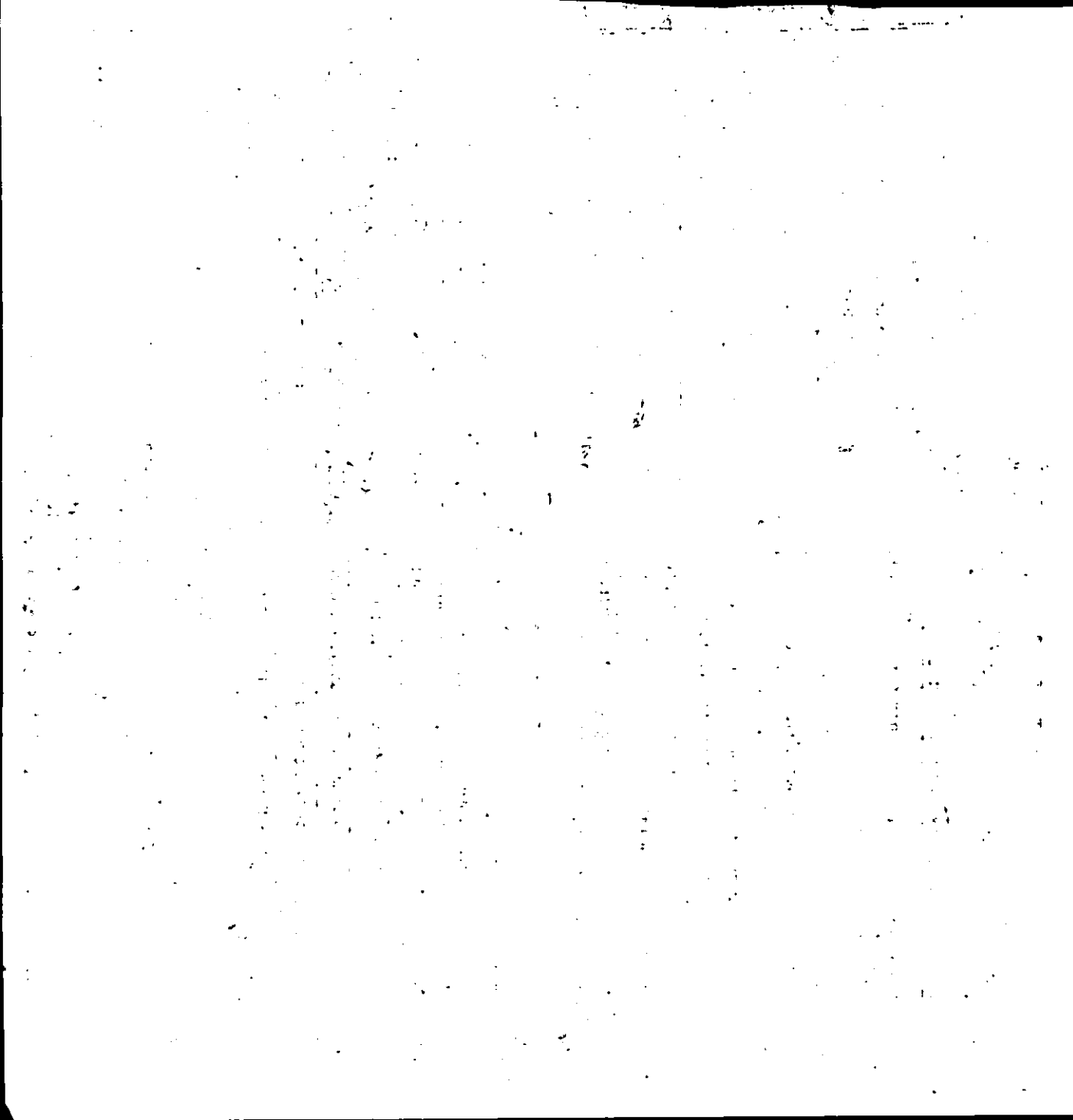
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Snider Cemetery Sept 23 1929

20. UNDERTAKER ADDRESS

A. M. Green Poplar Bluff Mo



**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 Butler

Registration District No. 89

File No. _____

Township _____

Primary Registration District No. 3007

Registered No. 156

City Doplar Bluff (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

M

4. COLOR OR RACE

W

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

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 2020 8 29 19 _____

Dr J J Cline
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Sept 21 1929

17.

I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, alive on _____, 19____, and that death occurred, on the date stated above, at _____, m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sept 18 1929 near
auto accident
fractured tibia
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

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

5 - 30 202