

DEC 20 1930

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

Do not use this space.

35546

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 130
 Township Welch Primary Registration District No. 5175
 City Delta (No.) St. Ward

File No.
 Registered No.
 St. Ward

2. FULL NAME

George Washington Snider
 (a) Residence. No. Delta Mo. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2. 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

Maudie Snider

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

Jan. 17-1866

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

65-66

10

2

8. OCCUPATION OF DECEASED

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

Black Smith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

9. BIRTHPLACE (CITY OR TOWN)

Millersville

(STATE OR COUNTRY)

Cape Girardeau

10. NAME OF FATHER

George W. Snider

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Cape Girardeau Mo

12. MAIDEN NAME OF MOTHER

Edinger

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Cape Girardeau Mo

14. INFORMANT

(Address)

John A. Snider, brother

15. FILED

11/30

1930

J. M. Magle

REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

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

Nov 29 1930

17.

I HEREBY CERTIFY, That I attended deceased from Nov 29 1930 to Nov 29 1930, and that I last saw him alive on Nov 29 1930, and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage

F.R.R.

97

CONTRIBUTORY (SECONDARY)

arterio sclerosis

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. W. Duvall, M.D.

, 19 (Address)

Allenville 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

Jackson City Cemetery

Nov 30 1930

20. UNDERTAKER

McCook & Co

ADDRESS

Jackson Mo

PHYSICIANS SHOULD
BATION A VERY

**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 Cape Girardeau
Township Wilcox
City (No.)

Registration District No. 130
Primary Registration District No. 5175

File No.
Registered No.
St. Ward

2. FULL NAME

George Washington 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 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) Jan 27 - 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 10 2

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 12/19/30 J. M. Slagle
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 29 1930

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:

CONTRIBUTORY (duration) yrs. mos. ds.
(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

SUPPLEMENTARY

Every item of information furnished on this certificate is required by law. It is the duty of the physician to fill out this certificate completely and to sign it. No statement or occupation is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-35546