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

Do not use this space.

35546-D

JAN 19 1931

1. PLACE OF DEATH

County: Cape Girardeau — Registration District No. 130

Township: Welch — Primary Registration District No. 5282

City: Delta Mo (No. ..... St. ..... Ward)

File No. .....

Registered No. .....

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 12 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 Maude Snider

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 27-1865

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: 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) .....
(STATE OR COUNTRY) Cape Gir Co. Mo.

PARENTS

10. NAME OF FATHER George W Snider

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Cape Gir. Co.

12. MAIDEN NAME OF MOTHER Catharine Edinger

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Cape Gir Co. Mo

14. INFORMANT John A. Snider
(Address) Jackson Mo.

15. FILED 12/18-, 1930 J M Slagle REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

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 that I last saw him alive on Nov 29, 1930, and that death occurred, on the date stated above, at 8 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82A
97 Cerebral hemorrhage

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

CONTRIBUTORY (SECONDARY) Arterio Sclerosis

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

18. WHERE WAS DISEASE CONTRACTED Yes
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) W M Dowell, 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
City Cemetery	Nov 30 1930
20. UNDERTAKER	**ADDRESS**
McCombs F & U Co.	Jackson 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.