

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

Do not use this space.

1. PLACE OF DEATH  
 46 County Howell Registration District No. 383 File No. 4479  
 Township Goldsberry Primary Registration District No. 5534 Registered No. 7  
 City Mountain View (No. ....) St. .... Ward ....

2. FULL NAME Elizabeth Snedden  
 (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 F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 27 - 1855

7. AGE YEARS 76 MONTHS 8 DAYS 30 If LESS than 1 day, .... hrs. or .... min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Housewife

10. Date deceased last worked at this occupation (month and year) July 1, 1932 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Kilwinning (STATE OR COUNTRY) Airshire, Scotland. 8

13. NAME Thomas Beverage

14. BIRTHPLACE (CITY OR TOWN) Scotland (STATE OR COUNTRY)

15. MAIDEN NAME Nellie Snedden

16. BIRTHPLACE (CITY OR TOWN) Scotland (STATE OR COUNTRY)

17. INFORMANT Wm. J. Snedden (ADDRESS) Mountain View, MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mountain View DATE 8-12-32 19.32

19. UNDERTAKER (ADDRESS) J. P. ...

20. FILED 2-29 19.32 J. P. ... Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-27-1932

22. I HEREBY CERTIFY, That I attended deceased from 2-27-1932 to 2-27-1932 82 I last saw h..... alive on 2-27-1932 82 Death is said

to have occurred on the date stated above, at 8 P.M. The principal cause of death and related causes of importance were as follows:

Corneal Al. edema Date of onset

GRA

Other contributory causes of importance: (1)

Name of operation ..... Date of ..... What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19..... Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury ..... Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Refused M. D.

(Address) Mountain View 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT

MAR 2 1932

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

Do not use this space.

**1. PLACE OF DEATH**

County Howell Registration District No. 383  
Township Sedberry Primary Registration District No. 5534  
City (No. ....) St. .... Ward)

File No. ....  
Registered No. 7

**2. FULL NAME**

Elizabeth Suedden  
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (with the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 27 - 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
76 8 30

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Keokuk, Iowa  
(STATE OR COUNTRY) Iowa - Scotland

10. NAME OF FATHER Chas. Deverage

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

12. MAIDEN NAME OF MOTHER Nellie Suedden

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

14. INFORMANT Wm. J. Suedden  
(Address) 1414 View, Mo

15. FILE NO. 2-29-32 Keokuk I 50  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 27 1932

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Apoplexy

CONTRIBUTORY (SECONDARY) gaw  
(duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH. (1)  
DID AN OPERATION PRECEDE DEATH? DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) G. E. Purcell, M. D.  
, 19 .. (Address) 1414 View - 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  
1414 View Mo 3-1 1932

20. UNDERTAKER ADDRESS  
John F. Duncan 1414 View

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.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

This is a corrected death  
certificate - It has been returned  
twice as the Dr. listed it cerebral  
accident - which was either  
embolism or apoplexy - but he  
has just listed it apoplexy this  
time

**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 Howell  
Township Baldsberry  
City (No. .... St. .... Ward)

Registration District No. 383  
Primary Registration District No. 3-5-34

File No. ....  
Registered No. 7

**2. FULL NAME**

Elizabeth Snedden

(a) Residence, No. .... St. .... Ward.  
(Usual place of abode)

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 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.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 2-24-32 1932 97/road

Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 27 1932

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on ..... 19..... Death is said

to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Cerebral accident (Cause of onset)

rather embolism

due to apoplexy

Other contributory causes of importance:

Name of operation ..... Date of

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) ..... M. D.

(Address)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

Applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE properly classified. Exact statement of OCCUPATION is very important.

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

N. B. - CAUSE

SUPPLEMENTARY