

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.

NOV 13 1934

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

Do not use this space.

36247

1. PLACE OF DEATH

County Jackson
Township North
City Lee Mo. (No. 1633, Lister)

Registration District No. 399
Primary Registration District No. 1002

File No. 47549
Registered No. 47549
St. _____ Ward _____

2. FULL NAME

Rosella Snider
(a) Residence, No. 1633 - Lister 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 <u>Fe</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Divorced</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Joseph H. Snider</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 30, 1890</u>				
7. AGE YEARS <u>44</u>	MONTHS <u>4</u>	DAYS <u>27</u>	If LESS than 1 day, _____ hrs. or _____ min.	
8. Trade, profession, or particular kind of work done, as spinner, Sawyer, bookkeeper, etc. <u>Housewife</u>				
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)
Mo

13. NAME David Huffman

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

15. MAIDEN NAME Mildred Williamson

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

17. INFORMANT Viglas Smith
(ADDRESS) 1633 - Lister

18. BURIAL, CREMATION, OR REMOVAL
PLACE Blue Springs DATE Oct. 29 1934

19. UNDERTAKER Rose E. Henderson
(ADDRESS) 1134 - E - 13

20. FILED 10/28 1934 M. M. Kerove
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 27 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
I last saw h. _____ 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:

Carcinoma of Uterus Date of onset 48
45
131
Other contributory causes of importance:
Chronic Nephritis

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) P. F. De Maria M. D.
(Address) and Sup. R. E. Kerove

