

SEP 19 1939

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

29058
Do not use this space.

1. PLACE OF DEATH
 (a) County Dunklin Registration District No. 286
 (b) Township Holcomb Primary Registration District No. 5404B Registered No. _____
 (c) City Holcomb (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred yrs. 4 mos. 28 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Glenda Lou Snider
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 28, 1939
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 3
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as 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) Holcomb Mo.
 FATHER 13. NAME Herschel Clifford Snider
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Holcomb Mo.
 MOTHER 15. MAIDEN NAME Frances Elizabeth Snider
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 17. INFORMANT (ADDRESS) H. C. Snider
Holcomb, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Stanfield DATE June 2, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. C. Fox
Holcomb, Mo.
 20. FILED Sept 9, 1939 H. Anderson
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-1st, 1939
 22. I HEREBY CERTIFY, That I attended deceased from 5-25, 1939, to 6-1st, 1939
 I last saw h. alive on 6-1st, 1939. Death is said to have occurred on the date stated above, at 4 P. m.
 The principal cause of death and related causes of importance were as follows:
Intussusception
Intercurrent
 Date of onset 5/27
 Other contributory causes of importance: Dehydrated
 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) Dr. E. C. ... M. D.
259 (Address) ...
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.

RECEIVED

District Health Officer No. 3

District File Number 989-57

Date Filed 9/13/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.