

NOV 14 1939

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

35914

Do not use this space.

1. PLACE OF DEATH *2*
- (a) County *Wade* Registration District No. *238*
- (b) Township *Lockwood Hospital* Primary Registration District No. *445* Registered No.
- (c) City *Lockwood Hospital* (d) Street No. (If death occurred in Hospital or Institution, write its name instead of street and number) St.
- (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME *1st Mrs. Nora Ethel Snowers*
- (a) Residence, No. *Miller Mo.* St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Female</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF <i>W.C. Clyde Snowers</i>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>1-1-1887</i>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<i>52</i>	<i>6</i>	<i>17</i>	
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) <i>Lawrence Co. Mo.</i>				
FATHER	13. NAME <i>Samuel A. Bassett</i>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ohio</i>			
MOTHER	15. MAIDEN NAME <i>Sarah A. Bond</i>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Ohio</i>			
17. INFORMANT (ADDRESS) <i>W.C. Snowers Miller Mo.</i>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Mount Snow</i> DATE <i>1939</i>				
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <i>Morris & Lemin Miller Mo.</i>				
20. FILED <i>7-20</i> 19 <i>39</i> <i>J. A. Wren</i> <i>215</i> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7-18-1939*

22. I HEREBY CERTIFY, That I attended deceased from *April 1, 1939* to *7-18-1939*, 19*39*
I last saw *her* alive on *7-18-1939* Death is said to have occurred on the date stated above, at *3 P.M.*
The principal cause of death and related causes of importance were as follows:
Hysterectomy of uterus for carcinoma Shock and hemorrhage
Other contributory causes of importance:
Hemorrhage of severe months

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) *W. S. Renna* M. D.
(Address) *Miller Mo.*

(Licensed Embalmer's Statement on Reverse Side)

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.

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 *L. P. Seimon*
Licensed Embalmer No. 3297
P. O. Address Miller Mo.

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.