DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21431

Registration District No. 1324 124 — Primary Registration District No. 3783 — Registrar's No. 24

1. PLACE OF DEATH
(a) County Cape Girardeau
(b) City or town Millersville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Whitewater Farm
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Cape Gir
(c) City or town Millersville (If outside city or town limits, write "RURAL")
(d) Street No. Whitewater Farm (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME JOHN CALHOUN SNIDER 536
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Susan Thompson Snider
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased May (Month) 16 (Day) 1850 (Year)

8. AGE: Years 90 | Months | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Bollinger County Mo (City, town, or county) (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business

MOTHER FATHER
12. Name Aaron Snider
13. Birthplace N. Carolina (City, town, or county) (State or foreign country)
14. Maiden name Cynthia Young
15. Birthplace N Carolina (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs James McDowell
(b) Address Charleston Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 12-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Snider Cemetery
18. (a) Signature of funeral director D Miller
(b) Address Jackson Mo
19. (a) 6-13-40 (Date received local registrar) (b) D. G. Seibert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 Th day 10 Th year 1940 hour 10:30 minute P. M.
21. I hereby certify that I attended the deceased from 6-7-40, 19__, to 6-10, 1940; that I last saw him alive on 6-10-, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Myocarditis	
Due to: Following Lung Abscess	
Due to (b): Following Fall	
Other conditions: Senility, Arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ✓
(b) Date of occurrence ✓
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ✓
(Specify type of place)
While at work? ✓ (e) Means of injury ✓

23. Signature Gilbert M Estes (M. D. or other)
Address Jackson, Mo. Date signed 6-12-40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should st
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa
I X19511

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 Lyman Steele

Licensed Embalmer No. 2476

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.

S. No. 2B
M—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21431

Registration District No. 124 Primary Registration District No. 5183 Registrar's No.

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) ~~City or town~~ White Water T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Calhoun Snider
3. (b) If veteran name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Wd
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 90 Months — Days 25 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 10
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from 19..., to 19...;
that I last saw h... alive on 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death (a) Acute myocarditis	
Due to, following long standing (b) Heart trouble	
Due to, (c) following a fall	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operation senility arteriosclerosis	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence 6-6-40
(c) Where did injury occur? Millersville (City or town) Mo (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? At Home (Specify type of place)
While at work? No (e) Means of injury fell against house

23. Signature Albert M. Eaton (M. D. or other)
Address Jackson Mo. Date signed