

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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 411 Primary Registration District No. 2002 Registrar's No.

1. PLACE OF DEATH:

(a) County. Jasper

(b) City or town. Joplin
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 314 South Division 2
(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. 42 years 532
(Specify whether years, months or days)

3. (a) PRINT FULL NAME. SARAH ALICE SNODGRASS

3. (b) If veteran, name war. _____ 3. (c) Social Security No. _____

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, widowed, married, divorced <u>Married</u>
6. (b) Name of husband or wife. <u>Robert Snodgrass</u>	6. (c) Age of husband or wife if alive. _____ years	
7. Birth date of deceased. <u>October 25 1891</u> <small>(Month) (Day) (Year)</small>		

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>8</u>	<u>28</u>	hr. _____ min.

9. Birthplace. Nichman Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation. at home

11. Industry or business. _____

MOTHER FATHER

12. Name. Unknown 9

13. Birthplace. _____
(City, town, or county) (State or foreign country)

14. Maiden name. Unknown 9

15. Birthplace. _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature. Robt Snodgrass

(b) Address. 314 South Division Joplin, Mo

17. (a) Burial (b) Date thereof July 25 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. Forest Park Cemetery

18. (a) Signature of funeral director. Lauber Mortuary

(b) Address. 1502 Joplin St Joplin, Mo

19. (a) 7-24-40 (b) E D Jarne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State. Missouri (b) County. Jasper

(c) City or town. Joplin
(If outside city or town limits, write "RURAL")

(d) Street No. 314 South Division
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1940 hour 10 minute _____ A. M.

21. I hereby certify that I attended the deceased from July 1 - 40 to July 23 40, 1940
that I last saw her alive on July 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death. Chronic Nephritis 240
Duration

Due to. _____

Due to. 121

Other conditions. _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations. _____

Of autopsy. _____

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? 272
(Specify type of place)

White at work? _____ Means of injury _____

23. Signature. H H Walker (M. D. or other) 1
Address. Joplin Mo Date signed 7/27/40

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 *F. M. Jones*

Licensed Embalmer No. *2319*

P. O. Address *Japhin 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.