

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Carter
Township Pike
City Fremont

Registration District No. 146
Primary Registration District No. 5209

File No. 31671
Registered No. _____
St. _____ Ward _____

2. FULL NAME Joseph Leonard Snider

(a) Residence, No. Fremont St. no Ward R.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 55 mos. 8 da. 10 How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Chloe Snider
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 14 1885
7. AGE YEARS 55 MONTHS 8 DAYS 10 If LESS than 1 day, _____ hrs. _____ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. farmer
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 life

12. BIRTHPLACE (CITY OR TOWN) Fremont, Mo.
(STATE OR COUNTRY)

FATHER
13. NAME Wilson Snider

14. BIRTHPLACE (CITY OR TOWN) Mc Kinn Co, Tennessee
(STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME Maleta June Snider

16. BIRTHPLACE (CITY OR TOWN) Co. Mo.
(STATE OR COUNTRY)

17. INFORMANT Wilson Snider
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Snider Cemetery DATE Sept. 24 1940

19. UNDERTAKER none
(ADDRESS)

20. FILED Oct. 10 1940 Marie D. Schaefer
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 23 1940

22. I HEREBY CERTIFY, That I attended deceased from 9-22 1940 to 9-23 1940

I last saw him alive on 9-23 1940 Death is said

to have occurred on the date stated above, at 7 P. m.

The principal cause of death and related causes of importance were as follows:

Uremic Poisoning Date of onset 1940

Other contributory causes of importance: Nephritis

Name of operation none Date of _____

What test confirmed diagnosis? urinal Was there an autopsy? no

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? no

If so, specify _____

(Signed) Wm. H. Burton, M. D.

(Address) San Bureau, Mo.

RECEIVED

District Health Officer No. 5,

District File Number 10401055

Date Filed _____

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **31671**

Registration District No. **146**

Primary Registration District No. **3209**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Carter**
(b) City or town **Pike 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)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **Joseph Leonard 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 **m**

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 **53** Months **8** Days **10** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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.

20. DATE OF DEATH Month **Sept** day **23** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death **uremia**

poisoning Duration **Sept 1940**

Due to **131**

Due to _____

Other conditions **rephritis** (Include pregnancy within 3 months of death) **chronic**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 31671

Registration District No. 146

Primary Registration District No. 5209

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Carter
(b) City or town Pike
(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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Joseph Leonard 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 m

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 55 Months 8 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

- MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

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

- (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a) March 1941 (b) Jessie S. Schupp
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Uremic poisoning

Due to _____

Due to _____

Other conditions nephritis
(Include pregnancy within 3 months of death) Chronic

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY