

No. 2
-13-40
17-39
X23159

FILED FEB 17 1941

Registration District No. 533

Primary Registration District No. 3027

Registrar's No. 13

1. PLACE OF DEATH: *Macon*
 (a) County *Macon*
 (b) City or town *Macon*
 (c) Name of hospital or institution: *Samaritan Hospital*
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution *29 hrs*
 In this community *0*
 years, months or days

3. (a) PRINT FULL NAME: *Joe Howard Snider*
 3. (b) If veteran, name war: _____
 3. (c) Social Security No.: _____

4. Sex: *Male*
 5. Color or race: *W*
 6. (a) Single, widowed, married, divorced: *0*
 6. (b) Name of husband or wife: _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: *Jan 7 - 1941*
 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____
 If less than one day _____ hr. _____ min.

9. Birthplace: *Macon, Macon Co. Mo.*
 (City, town, or county) (State or foreign country)

10. Usual occupation: *Infant*

11. Industry or business: _____

12. Name: *Joseph Snider*
 13. Birthplace: *Mo.*
 (City, town, or county) (State or foreign country)

14. Maiden name: *Elizabeth M. Neely*
 15. Birthplace: *Macon Co. Mo.*
 (City, town, or county) (State or foreign country)

16. (a) Informant: *Mr. R. Wilson Barron*
 (b) Address: *Macon, Mo.*

17. (a) *Burial* (b) Date thereof: *1 - 9 - 41*
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director: *Stephen Gooding*
 (b) Address: *Macon, Mo.*

19. (a) *2/7/41* (b) *Geo. Hendon*
 (Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: *MO* (b) County: *Macon*
 (c) City or town: *Macon*
 (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.? *0* years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month *Jan* day *8*
 year *41* hour *8* minute *P.* M.
 21. I hereby certify that I attended the deceased from *Jan 7*
 19 *41* to *Jan 8*, 19 *41*
 that I last saw *him* alive on *Jan 8*, 19 *41*
 and that death occurred on the date and hour stated above.

Immediate cause of death: *Cerebral hemorrhage*
 Duration: *1 day*

Due to: *Injury in both Canal*

Due to: _____

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

Major findings: _____
 Of operations: *1602*
 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?
475

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

23. Signature: *J. S. Turner* (M. D. or other) *0*
 Address: *Macon, Mo.* Date signed: *2/7/41*

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 2-41-317

Date Filed FEB 14 1941

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~~ *not embalmed by me*

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

working under my personal supervision.

Signed *C. L. Stephens*

Licensed Embalmer No. *3057*

P. O. Address *Macon, 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, fact should be so stated above.