

FILLED NOV 14 1941

Registration District No. **287**

Primary Registration District No. **5405**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Franklin**
(b) City or town **Franklin**
(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 **BETTIE FAY SNEED**

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

4. Sex **F** Color or race **W** 6. (a) Single, widowed, divorced, **S O**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased **Aug 16 41**
(Month) (Day) (Year)

8. AGE: Years _____ Months **1** Days **8** If less than one day _____ by _____ min.

9. Birthplace **Hammersville Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Sterling Sneed**

13. Birthplace **Franklin Mo**
(City, town, or county) (State or foreign country)

14. Maiden name **Sterling**

15. Birthplace **Franklin Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Sterling Sneed**

(b) Address **Franklin Mo**

17. (a) _____ (b) Date thereof **10/8/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hammersville**

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) **10/8/41** (b) **C. E. Cope**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Franklin**
(c) City or town **Franklin** 3.5
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **7**
year **1941** hour **8** minute **00** A.M.

21. I hereby certify that I attended the deceased from **Aug 16** 1941 to **Oct 7** 1941
that I last saw _____ alive on **Oct 4** 1941
and that death occurred on the date and hour stated above.

Immediate cause of death **Gastro-Enteritis 7. Wk**

Due to **Man. Assimim-**

Due to _____

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

Major findings: **119a**
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? **Yes** (Specify type of place) _____ (Specify means of injury)

23. Signature **C. E. Cope** (M. D. or other) **D**
Address **Hammersville Mo**

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

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1141-1535

Date Filed 11/2/41

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.....

Licensed Embalmer No.....

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, fact should be so stated above.