

33282

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 23 1942

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 965

1. PLACE OF DEATH:

(a) County Buchanan,
(b) City or town Saint Joseph,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2822 Angelique Street,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
In this community 40 years,
years, months or days)

3. (a) PRINT
FULL NAME

Joseph Edson Snider,

3. (b) If veteran,

name war None,

3. (c) Social Security

No. 491-10-9746

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed,
6. (b) Name of husband or wife Cora E. Snider, 6. (c) Age of husband or wife if alive years
7. Birth date of deceased December 17th, 1867
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 9 22 hr. min.

9. Birthplace Athens County, Ohio, /
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter,

11. Industry or business Foreman

12. Name John W. Snider,
13. Birthplace Unknown, Ohio, /
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth James,
15. Birthplace Unknown, Indiana, /
(City, town, or county) (State or foreign country)

16. (a) Informant John W. Snider
(b) Address 2822 Angelique Street,
Burial (b) Date thereof 10 11/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cash Cemetery, New Cambria, Mo.

18. (a) Signature of funeral director William Beaman-Turner
(b) Address 319 So. 10th Street, Homer
19. (a) 10-11-42 (b) Rose Skrzog
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Buchanan 11
(c) City or town Saint Joseph, 2
(If outside city or town limits, write "RURAL")
(d) Street No. 2822 Angelique
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country. 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 9th.
year 1942 hour 1:00 minute 45 p.m.

21. I hereby certify that I attended the deceased from Jan, 3
1941, to Oct 1942,
that I last saw him alive on Oct 1 1942,
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma
of mouth and pharynx 2 yrs
Complicated by asphyxiation and
vascular insufficiency.
Due to vascular insufficiency.

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 45C

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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?

(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 11

23. Signature Dr. John Harbuck (M.D. or other) D.O.
Address 222 Logan Bldg Date signed Oct 10, 42

1233 (Licensed Embalmer's Statement on Reverse Side)

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

OCT 27 1942

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, ~~on~~ Oct. 9, 1942

....., Registered Apprentice No.,
working under my personal supervision.

Signed

Wm. E. Summerfield

Licensed Embalmer No. 3007

P. O. Address 319 So 1st St Joseph 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.