DM—5-42
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X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1943

Registration District No. 146

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3026

State File No. 2490

Registrar's No. 24

1. PLACE OF DEATH:

(a) County: Jackson

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

(c) Name of hospital or institution: Independence San. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 6 days (Specify whether years, months or days)

In this community: 15 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Independence (If outside city or town limits, write "RURAL")

(d) Street No.: 408 W. Rude (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: No

3. (a) PRINT FULL NAME: LOLA MAE SNOW

3. (b) If veteran, name war: No

3. (c) Social Security No.: 490-09-2485

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: divorced

6. (b) Name of husband or wife: —

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: Oct. (Month) 2 (Day) 1913 (Year)

8. AGE: Years 29 Months 3 Days 15 If less than one day hr. min.

9. Birthplace: Iola (City, town, or county) Kansas (State or foreign country)

10. Usual occupation: Saleswoman

11. Industry or business: Knepker Clo. Co.

MOTHER FATHER

12. Name: John Snavely

13. Birthplace: Chillicothe (City, town, or county) Missouri (State or foreign country)

14. Maiden name: Mary Ella Drake

15. Birthplace: Iola (City, town, or county) Kansas (State or foreign country)

16. (a) Informant: Eleotus Snow

(b) Address: 1217 W. Linden

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1/20/43 (Month) (Day) (Year)

(c) Place: burial or cremation: Mound Grove Cem.

18. (a) Signature of funeral director: George C. Carson

(b) Address: Independence Mo.

19. (a) 1-20-1943 (Date received local registrar) (b) James Wood (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17 year 1943 hour 11.50 minute A.M.

21. I hereby certify that I attended the deceased from Jany 11, 1943, 19.., to Jany 17, 1943 and that I last saw her alive on Jany 17, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death: Left massive lobar pneumonia — 5 days

Due to: Diabetic coma — 2 days

Due to: Diabetes Mellitus — 3 years

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

Major findings:

Of operations:

Of autopsy:

Duration

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: John L. Drake (M. Dr. or other)

Address: Independence Mo. Date signed: 1/18/43

(Licensed Embalmer's Statement on Reverse Side)

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 Frank Fou 6

Licensed Embalmer No. 2467

P. O. Address Sidep. 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.

U. S. No. 2B
OM—8-21-41
X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2490

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 24

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

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Independence

(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 years, months or days)

In this community

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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Lola May Snow

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Oct (Month) 2 (Day) 1873 (Year)

8. AGE: Years 29 Months 3 Days If less than one day hr. min.

9. Birthplace: (City, town, or county) Kansas (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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 17 year 1943 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: Left Massive Lobar pneumonia — Duration 5 days

Due to: Diabetes coma — 6 days

Due to: Diabetes mellitus — 3 yrs

Due to: 61

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

Major findings:

Of operations: (not gonorrhea)

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (c) Means of injury

23. Signature: Paul Grobske (M. D. or other)

Address: Independence Ohio Date signed: 3/3/43

SUPPLEMENTARY