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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19253
Registrar's No. 37

FILED JUN 8 1943
Registration District No. 337

Primary Registration District No. 6141

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

1. PLACE OF DEATH:

(a) County Shelby

(b) City or town Hannibal - Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson Army
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community Life years, months or days (Specify whether)

3. (a) PRINT FULL NAME MARTHA JOSEPHINE SNIDER

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female 5. Color or face White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Myrl Snider 6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased Aug 24 - 1902
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>40</u>	<u>18</u>		hr. min.

9. Birthplace Shelby Co. Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Fred Cochran

13. Birthplace Shelby Co. Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Blanche Kelley

15. Birthplace Shelby Co. Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Myrl Snider

(b) Address Hannibal, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/9/43
(Month) (Day) (Year)

(c) Place: burial or cremation Hannibal Cemetery

18. (a) Signature of funeral director Metzler & Barkley

(b) Address Shelby Mo

19. Myrl - 1943 (b) Malge Good
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Shelby ¹⁰²

(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr - day 6
year 1943 hour 5:30 minute p. M.

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

Immediate cause of death Arterio Sclerosis of the Heart ?
Duration _____

Due to _____

Due to _____

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

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 E. P. Thompson Coverer
(M. D. or other)

Address Shelbyville, Mo. Date signed _____

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

9504

RECEIVED

District Health Officer No. 10

District File Number 6-43-971

Date Filed JUN 7 1943

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.....

Henry A. Darst

Licensed Embalmer No. 3835

P. O. Address Shelburne, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 337

Primary Registration District No. 6141

Registrar's No. 37

1. PLACE OF DEATH

(a) County Shelby
(b) City or town Rural
(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 _____ life (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby
(c) City or town Hannibal Rural
(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 Martin J Snider

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased Aug 24 - 1902
(Month) (Day) (Year)

8. AGE: Years 40 Months 4 Days 5 (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____, that I saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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

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) _____

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

MOTHER FATHER

5-19253