

Registration District No. 208

Primary Registration District No. 57624320 Registrar's No. 576247

1. PLACE OF DEATH:  
(a) County Marion  
(b) City or town Palmyra Mo  
(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 1 (Specify whether  
In this community 40 yrs years, months or days)

3. (a) PRINT FULL NAME Joseph Martin Snow  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced 1  
6. (b) Name of husband or wife Lola Mae Snow 6. (c) Age of husband or wife if alive 53 years  
7. Birth date of deceased June 8 1870 (Month) (Day) (Year)

8. AGE: Years 73 Months 3 Days 22 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Ben Franklin Snow  
13. Birthplace Iowa (City, town, or county) (State or foreign country)  
14. Maiden name Maitha Jane Walker  
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Lola Mae Snow  
(b) Address Palmyra, Mo

17. (a) Burial (b) Date thereof Oct 2-43 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ewing, Mo.

18. (a) Signature of funeral director Thomas Ball  
(b) Address Ewing, Mo.

19. (a) Oct 2-43 (b) Mrs. Margaret Madley (Date received local registrar) (Registrar's signature)  
1145 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri County Marion 064  
(c) City or town 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 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30  
year 1943 hour 9 minute a. M.

21. I hereby certify that I attended the deceased from Sept 20 1943, to Sept 30 1943  
that I last saw him alive on Sept 27 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 10 m  
Due to Coronary Sclerosis + Hypertension 1 year  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 94 a  
Major findings:  
Of operations \_\_\_\_\_  
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? no  
While at work? \_\_\_\_\_ (Specify type of place) (e), Means of injury \_\_\_\_\_

23. Signature J. P. Kramer (M. D. or other) D.O.  
Address Palmyra Mo Date signed 10/1/43

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

**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..... *Thomas Ball* .....

Licensed Embalmer No. *1744* .....

P. O. Address..... *Ewing, 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.**

Registration District No. 208 Primary Registration District No. 4320

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

**1. PLACE OF DEATH:**

(a) County Marion

(b) City or town Palmyra  
(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 \_\_\_\_\_ (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Joseph Mathias Snow

**3. (b) If veteran** name war \_\_\_\_\_ **3. (c) Social Security No.** \_\_\_\_\_

**4. Sex** M **5. Color of race** W

**6. (a) Single, widowed, married, divorced** Married

**6. (b) Name of husband or wife** Lola Mae Snow **6. (c) Age of husband or wife if alive** \_\_\_\_\_ years

**7. Birth date of deceased** June 8 (Month) (Day) (Year)

**8. AGE:** Years 73 Months 2 Days \_\_\_\_\_ (Unless than one day) min. \_\_\_\_\_

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

**10. Usual occupation** \_\_\_\_\_

**11. Industry or 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)** \_\_\_\_\_ (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)

**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 \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Sept day 10 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

**21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last 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 \_\_\_\_\_

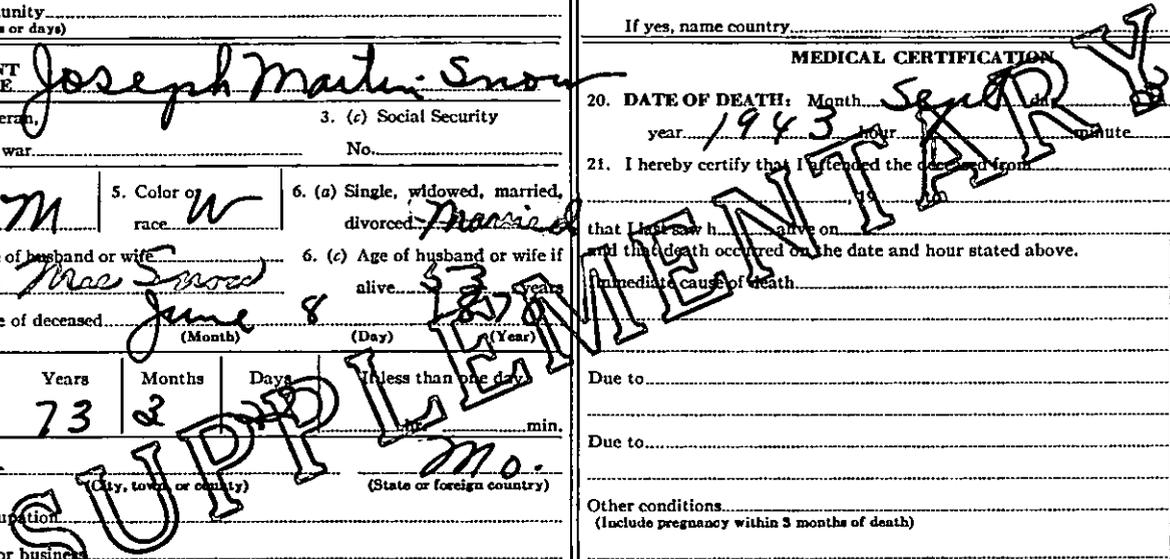
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(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)

**Address** \_\_\_\_\_ **Date signed** \_\_\_\_\_



MOTHER, FATHER

**Duration** \_\_\_\_\_

**PHYSICIAN** \_\_\_\_\_

Underline the cause to which death should be charged statistically.

35249