

FILED JAN 12 1944

Registration District No. _____

Primary Registration District No. 4296

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Sullivan**
(b) City or town **Browning**
(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 **5 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Sullivan 105**
(c) City or town **Browning**
(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 _____

3. (a) PRINT FULL NAME **Hester Ann Snyder**

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

4. Sex **Fe** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **John W. Snyder** 6. (c) Age of husband or wife if alive **87** years
7. Birth date of deceased **April 12 1864**
(Month) (Day) (Year)

8. AGE: **79** Years **9** Months **20** Days If less than one day
hr. _____ min. _____

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

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **Samuel Owings**
13. Birthplace **virginia**
(City, town, or county) (State or foreign country)
14. Maiden name **Nancy Williams**
15. Birthplace **virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Goldie Williams**
(b) Address **Browning, Mo.**

17. (a) **Burial** (b) Date thereof **Jan 8 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove**

18. (a) Signature of funeral director **C. C. Hopper**
(b) Address **Clarince**

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **6**
year **1944** hour **9** minute **15 A. M.**

21. I hereby certify that I attended the deceased from **Dec 28**, 19**43** to **Jan 6**, 19**44**
that I last saw her alive on **Jan 6**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary thrombosis** Duration **Minutes**

Due to _____

Due to _____

Other conditions **Dyspepsia** **2 week**
(Include pregnancy within 3 months of death)

Major findings: Of operations **gfa**

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 **J. P. McArdle** (M. D. or other) _____
Address **Browning Mo** Date signed **Jan 6**

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

1502

8-1944

RECEIVED

District Health Officer No. 10

District File Number 1-44-89

Date Filed JAN 11 1944

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.....

Louis C. Hopper

Licensed Embalmer No.....

7261

P. O. Address.....

Clarence 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. 350

Primary Registration District No. 4296

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Sullivan
(b) City or town Browning
(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 5 yrs years, months or days

3. (a) PRINT FULL NAME Walter A Snyder

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 M

6. (b) Name of husband or wife John W Snyder 6. (c) Age of husband or wife if alive 87 year

7. Birth date of deceased: Apr 12 - 1867 (Month) (Day) (Year)

8. AGE: Years 79 Months 9 Days 2 If less than one day _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Samuel Clivings

13. Birthplace Virginia (City, town, or county) (State or foreign country)

14. Maiden name Nancy Williams

15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Eddie Williams (b) Address Browning Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereon Nov 8 - 1944 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove

18. (a) Signature of funeral director E E Fisher (b) Address Clarence Mo

19. (a) Jan 15 1944 (b) Mrs. C. C. Woolf (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Sullivan
(c) City or town Browning
(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 Jan Day 6 Year 1944 Hour 2 minute 00 M.

21. I hereby certify that I attended the deceased from Dec 15 1943 - 2046 1944 that I last saw him alive on Jan 6 - 1944 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration _____

Due to _____
Due to _____

Other conditions Influenza (Include pregnancy within 3 months of death) 2 wks

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature G. R. McArthur (Date signed Jan 8 - 1944)
Address Browning Mo

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

Supplemental

MOTHER FATHER

4701