

FILED JUN 7 1944
Registration District No. **47**

Primary Registration District No. **3008**

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton, Missouri**
(c) Name of hospital or institution: **Callaway County Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **ABOUT TWO HOURS**
In this community **Lifetime**
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Callaway**
(c) City or town **Fulton** (If outside city or town limits, write "RURAL")
(d) Street No. **302 Court St.** (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MARTHEA MAE SNOW**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Fe** 5. Color or race **Wn** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **NOV 7 1932**
(Month) (Day) (Year)

8. AGE: Years **11** Months **6** Days **23** If less than one day hr. min.

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

10. Usual occupation **Student**

11. Industry or business **Student**

12. Name **Curtis C. Snow**

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

14. Maiden name **Bessie Martin**

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

16. (a) Informant **Curtis C. Snow**

(b) Address **302 Court, St. Fulton, Mo.**

17. (a) **Burial** (b) Date thereof **5/1/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hilicrest**

18. (a) Signature of funeral director **Wallace Funeral Home**
Fulton, Mo.

(b) Address **D. G. Browning, Inc.**

19. (a) **6-1-44** (b) **Joie M. ...**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **30**
year **1944** hour **5** minute **45 P.** M.
21. I hereby certify that I attended the deceased from **May 5**
1944 to **May 5**, 1944
that I last saw her alive on **May 5**, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxiation** Duration **3 min.**

Due to **convulsing under ether**
anesthesia.

Due to **Fract. R. radius & ulna.**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **none**

Of autopsy **none**

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

22. If death was due to external causes, fill in the following: **V014**

(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) _____ means of injury _____

23. Signature **John P. Brown** (M. D. or other) **D**

Address **Fulton, Mo.** Date signed **5-27-44**

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

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JUN 24 1944

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 6-6-44

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 _____

Licensed Embalmer No. 4768

P. O. Address Fulton, 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. 47 Primary Registration District No. 3008

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

1. PLACE OF DEATH:

(a) County Callaway

(b) City or town Fulton
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Martha Mae 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 S

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

7. Birth date of deceased Nov. (Month) 7 (Day) 1945 (Year)

8. AGE: Years 11 Months 6 Days 3 If less than one day, _____ min.

9. Birthplace _____ (City, town, or county) _____ (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) _____ (b) _____ (Date received local registrar) (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 May year 1945 hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

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

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) Accident

(b) Date of occurrence May 30, 1945

(c) Where did injury occur? Fulton Callaway Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? No (Specify type of place) Means of injury fall

23. Signature John J. Brown (M.D. or other)

Address _____ Date signed 6-19-45

SUPPLEMENTARY

17640