

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34285  
34

State File No.

Registrar's No.

FILED NOV

6 1944

Registration District No.

Primary Registration District No.

2000

841

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town SPRINGFIELD  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1635 E. THOMAN  
(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 JAMES PHILLIP SNIDER

3. (b) If veteran, name war NONE 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced 3 divorced DEVELOPED  
6. (b) Name of husband or wife UNK. 6. (c) Age of husband or wife if alive UNK. years  
7. Birth date of deceased Oct. 30, 1857  
(Month) (Day) (Year)

8. AGE: Years 86 Months 11 Days 22 If less than one day  
✓ hr. min.

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

10. Usual occupation Farmer (Retired 1 yr.)

11. Industry or business Farming

12. Name Mr. Snider

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

14. Maiden name UNK. unknown

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

16. (a) Informant George Snider

(b) Address Springfield, Mo.

17. (a) Buried (b) Date thereof Oct 25-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Forest Cem.

18. (a) Signature of funeral director J. W. Klingner

(b) Address Springfield, Mo.

19. (a) 10-24-44 (b) J. D. W. Handy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39  
(c) City or town Springfield 2  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1635 E. Thoman 6  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22  
year 1944 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 10-15- 1944 to 10-22- 1944  
that I last saw him alive on 10-22- 1944  
and that death occurred on the date and hour stated above

Immediate cause of death Edema of Lungs Duration  
Valvular Heart Disease

Due to Bright's Disease

Due to arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 92d

Of autopsy 92d **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 time of place) (a) Manner of injury \_\_\_\_\_

23. Signature James E. Smith Date signed 10/25/44  
Address 450 1/2 E. Council

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

Licensed Embalmer No. 4071

P. O. Address Springfield

**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.**