

FILED JAN 5 1945
Registration District No. **3039**

Primary Registration District No. **3039**

1. PLACE OF DEATH:
(a) County **Linn**
(b) City or town **Marceline**
(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 **1**
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME **Anthony Lee Snider**
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **male** 5. Color or race **white** 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 **December 30 1944**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 15 hr. 15 min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name **Victor Snider**
13. Birthplace **Marceline Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Addie Gerott**
15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Victor Snider**
(b) Address **Marceline Mo**
17. (a) **Burial** (b) Date thereof **Dec 31 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Int. Olivet**
18. (a) Signature of funeral director **James M. Laughlin**
(b) Address **Marceline Mo**
19. (a) **1-1-45** (b) **P. J. Partridge MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Linn**
(c) City or town **Marceline**
(If outside city or town limits, write "RURAL")
(d) Street No. **1**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **31**
year **1944** hour **2** minute **00 A.M.**

21. I hereby certify that I attended the deceased from **Birth** to **1944**
that I last saw him alive on **Dec. 30**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis**
Due to **prematurity**
(7 mo. gestation)
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy
159
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) (c) Means of injury
23. Signature **Louise V. Aubert** (M. D. or other)
Address **Marceline Mo** Date signed **1-1-45**

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.....

P. O. Address.....

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.