

No. 2  
-5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41852

State File No. ....

FILED JAN 10 1945

Registration District No. 274

Primary Registration District No. 5929

Registrar's No. 398

1. PLACE OF DEATH:

(a) County Cattis  
(b) City or town Houstonia (Rural)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Houstonia  
(If not in hospital or institution, write street number or location) my  
(d) Length of stay: In hospital or institution 10 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carters  
(c) City or town Jasper (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 ---

3. (a) PRINT FULL NAME Dora Lee Snyder

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

20. DATE OF DEATH: Month Dec day 2  
year 1944 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Nov 23, 1944, to Dec 1, 1944

that I last saw her alive on Dec 1, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Edema legs + abdomen  
Due to Weak heart

Due to age

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations X  
Of autopsy ---

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) X  
(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?

23. Signature C. L. Parkhurst (Specify type of place) (e) Years of injury  
Address Houstonia Mo Date signed Dec 3 1944

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M  
6. (b) Name of husband or wife A J Snyder 6. (c) Age of husband or wife if alive 74 years  
7. Birth date of deceased Oct 16 1869  
(Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 16 If less than one day hr. min.

9. Birthplace Cooper Co Mo  
(City, town or county) (State or foreign country)

10. Usual occupation house helper

11. Industry or business ---

12. Name James M Adams

13. Birthplace Cooper Co Mo  
(City, town or county) (State or foreign country)

14. Maiden name Dulcinea Johnson

15. Birthplace Cooper Co Mo  
(City, town or county) (State or foreign country)

16. (a) Informant J M Adams

(b) Address Houstonia Mo

17. (a) burial (b) Date thereof Dec 4 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blackwater Chapel

18. (a) Signature of funeral director Westbrook

(b) Address Houstonia Mo

19. (a) 12-13-44 (b) Mrs Anna Berger  
(Date received local registrar) (Registrar's signature)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

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

1022

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 1-2-45.....

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 A. H. Smiley.....

Licensed Embalmer No. 3987.....

P. O. Address Houston, Texas.....

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan 398  
Registrar's No. \_\_\_\_\_

Registration District No. 274 Primary Registration District No. 5929

1. PLACE OF DEATH:

(a) County Pettis  
(b) City or town Rural Houstonburg  
(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 Dora Lee Snyder

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 m

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

7. Birth date of deceased Oct 16  
(Month) (Day) (Year)

8. AGE: Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

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

FATHER  
MOTHER

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (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 Dec day \_\_\_\_\_ year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to Myocardial Infarction

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

ADDITIONAL SUPPLEMENTARY INFORMATION

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) (a) Means of injury \_\_\_\_\_

23. Signature C. L. Posthumus (M. D. or D.V.M.)

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

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

SUPPLEMENTARY

S-41852 -1944