

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. _____

Registration District No. 23

Primary Registration District No. 11034

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Bates County
 (b) City or town Hume, Missouri
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
No
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 26 Years
years, months or days)

3. (a) PRINT FULL NAME William Edward Snow
 3. (b) If veteran, name war No
 3. (c) Social Security No. _____

4. Sex Male
 5. Color or race W.
 6. (a) Single, widowed, married, divorced, Widowed
 6. (b) Name of husband or wife (Mary Elizabeth)
 6. (c) Age of husband or wife if alive Deceased
 7. Birth date of deceased Oct. 30th. 1864
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 14
If less than one day
 _____hr. _____min.

9. Birthplace Augusta County Va.
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer (Retired)
Rec. Charge Lumb. Co.

11. Industry or business Unknown

12. Name _____

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

14. Maiden name Angeline Campbell

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

16. (a) Informant Son, Thomas Snow
 (b) Address Hume, Mo.

17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof 5-18-45
(Month) (Day) (Year)
 (c) Place: burial or cremation Hume Cemetery

18. (a) Signature of funeral director _____
 (b) Address _____

19. (a) 5-18-45
(Date received local registrar) (b) Mrs Margaret Shaw
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
Missouri Bates 7
 (a) State _____ (b) County _____
 (c) City or town Hume
(If outside city or town limits, write "RURAL")
 (d) Street No. N.E. Part
(If rural, give location)
 (e) Citizen of foreign country? No
(Yes or No)
 If yes, name country _____

DR. Harry Allen MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14
 year 1945 hour 1:30 minute P. M.

I hereby certify that I attended the deceased from May 11, 1945 to May 14, 1945
 that I last saw him alive on May 14 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
 Duration 3 days

Due to Hypertension
 Duration 1 yr

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

Major findings: None
 Of operations _____
 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:

(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 _____

Signature Dr. Harry Allen (M. D. _____)
 Address Hume Date signed 5/17/45

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

MOTHER FATHER

1581

W. H. [unclear] → Ad. [unclear]

RECEIVED

District Health Officer - No. 7

District File Number 4-45-466

Date Filed 5-25-45

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed J. Hudson Penley

Licensed Embalmer No. 2730

P. O. Address Rich Hill 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.