

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 14 1945
Registration District No. 99

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16760
Registrar's No. 36

Primary Registration District No. 5373

1. PLACE OF DEATH:

(a) County DEKALB
(b) City or town AMITY (RURAL)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Carmel Nursing
(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 HETTIE ERENE SNELLING

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, 2nd W

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

7. Birth date of deceased DEC 14 1857
(Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 1 If less than one day
hr. _____ min. _____

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

10. Usual occupation HOUSE WIFE

11. Industry or business _____

12. Name MARK DENNEY

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

14. Maiden name HAURA COOK

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

16. (a) Informant Bernice B Snelling

(b) Address Amity Mo

17. (a) Burial (b) Date thereof 5/17/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Amity

18. (a) Signature of funeral director WALTER J. JONES

(b) Address WYLSVILLE MO

19. (a) 516-45 (b) John Clarke
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County DEKALB
(c) City or town AMITY (RURAL)
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 15
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 2nd 1943 to May 15th 1945
that I last saw him alive on May 15th 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis Duration 2 3/40

Due to _____

Due to _____

Other conditions arterio Sclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 930

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? _____

(Specify type of place) _____
While at work? _____ (a) Means of injury _____

23. Signature W. J. Jones (M.D. or other) _____

Address Marquette Mo Date signed 5/16/45

1378

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 11.

District File Number

Date Filed

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.