

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16761

State File No.

Registrar's No. 39

FILED JUN 14 1945

Primary Registration District No. 4168

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

1. PLACE OF DEATH:

(a) County DE KALB
(b) City or town MAYSVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 60 days (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME GEORGE EDDY SNIDER

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

4. Sex MA 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased FEB-17-1853 (Month) (Day) (Year)

8. AGE: Years 92 Months 3 Days 15 If less than one day hr. _____ min. _____

9. Birthplace CLARK CO. IND. (City, town, or county) (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business _____

12. Name WILLIAM SNIDER

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

14. Maiden name JANE KELLEY

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

16. (a) Informant EDDY SNIDER

(b) Address MAYSVILLE MO

17. (a) BURIAL (b) Date thereof 6-4-45 (City or town) (County) (State)

(c) Place of burial OAK LAWN MAYSVILLE

18. (a) Signature of funeral director WALTER FUNKER

(b) Address MAYSVILLE MO

19. (a) 6-4-45 (b) John Clark (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County DE KALB
(c) City or town MAYSVILLE 32
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 2
year 1945 hour 5 minute 0 P. M.

21. I hereby certify that I attended the deceased from May 12, 1945, to June 2, 1945
that I last saw him alive on June 2, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis Duration 3 weeks

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 940

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 _____

23. Signature Dr. Harold Fowler D. O. Brother J. D. O.
Address Maysville, Mo Date signed 1945

1378

(Licensed Embalmer's Statement on Reverse Side)

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
working under my personal supervision.

Signed *[Signature]*
Registered Apprentice No. _____
Licensed Embalmer No. *3960*
[Signature]

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.

RECEIVED
State Health Officer No. 111
Date Filed _____
Official File Number _____