

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

JUL 12 1945

Registration District No. 53

Primary Registration District No. 3799

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Boyard - Rural
(c) Name of hospital or institution Home 3M. NW Boyard
(d) Length of stay: In hospital or institution _____
(If not in hospital or institution, write street number or location)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Charles Marion Snider

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

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

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

7. Birth date of deceased May - 30 - 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months 0 Days 16
If less than one day _____ hr. _____ min.

9. Birthplace near Boyard - Carroll Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Alba Lee Snider

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

14. Maiden name Mattie Ethel Workfield

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

16. (a) Informant Alba Lee Snider

(b) Address Boyard - Mo

17. (a) Burial (b) Date thereof 6/17/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Truett Cem.

18. (d) Signature of funeral director Clifford W. Justice

(b) Address Texas Missouri

19. (a) 6-17-45 (b) Mr. James R. Kelly
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll
(c) City or town Boyard - Rural
(d) Street No. _____
(e) Citizen of foreign country? _____
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16
year 1945 hour 5:30 minute A. M.

21. I hereby certify that I attended the deceased from June 15
1945 to June 16 1945;
that I last saw him alive on June 15 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Debility Duration 16 days

Due to Not Known

Due to _____

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

Major findings: Of operations _____

Of autopsy 158

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? _____

(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 2

23. Signature Dr. R. W. Matheny (or other) 100

Address Lina Missouri Date signed 6/18/45

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

9/11/45

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

Clifford W. Austin

Licensed Embalmer No.

3233

P. O. Address

Tina, Missouri

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.