

FILED JAN 9 1947

Registration District No. 37

Primary Registration District No. 4049

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Centralia
(b) City or town Centralia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1 city
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community life years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME MOLLIE CRIGGS
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 22nd
year 1946 hour 6 minute 30 A M.
21. I hereby certify that I attended the deceased from 3-13-42
_____, 19____, to 12-22-46, 19____.

4. Sex F 5. Color pr W race _____
6. (a) Single, widowed, married, divorced widow
(b) Name of husband Robert Snyzer
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug-28-1872
(Month) (Day) (Year)

that I last saw her alive on 12-21-46, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 9 weeks

8. AGE: Years 74 Months 3 Days 24 If less than one day
hr. _____ min. _____

Due to Anticoagolin

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

Due to Hypertension

10. Usual occupation _____

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

MOTHER FATHER
11. Industry or business _____
12. Name H. H. Smith
13. Birthplace Boone Co. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Marned Snyzer
15. Birthplace Mo.
(City, town, or county) (State or foreign country)

Major findings: Of operations 938
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Betty Barnes
(b) Address Centralia, Mo
17. (a) Burial (b) Date thereof Dec. 24, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

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?

(c) Place: burial or cremation Columbia, Mo
18. (a) Signature of funeral director Mrs. J. J. ...
(b) Address Centralia, Mo
19. (a) Jan 1-1947 (b) Maud M. Brude
(Date received local registrar) (Registrar's signature)

While at work? 12 (Specify type of place) (c) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address Centralia, Mo. Date signed 12-23-46

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
38433

RECEIVED
District Health Officer No. 9,

District File Number-----
~~Date Filed 1-8-47~~

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 *John Jamison*
Licensed Embalmer No. 4270
P. O. Address Centralia 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.