

No. 2  
12-45  
17-39  
X47070

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16968

FILED JUN 2 1947

State File No. \_\_\_\_\_

Registration District No. 82

Primary Registration District No. 30175309

Registrar's No. 74

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville Rural  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
At home  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community All of life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

(c) City or town Boonville  
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. #4  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mollie Elizabeth Snider

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9 year 1947 hour 1 minute \_\_\_\_\_ a. M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced, widowed

6. (b) Name of husband or wife Robert Snider

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 30 1860  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Apr 19, 1947 to May 9, 1947  
that I last saw her alive on April, 1947  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

87 1 9 hr. \_\_\_\_\_ min.

Immediate cause of death myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace Boonville, Missouri  
(City, town, or county) (State or foreign country)

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

10. Usual occupation Housewife.

11. Industry or business At home

Major findings: none

Of operations none

Of autopsy none

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Adam Scott

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

14. Maiden name Kate Gentry

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

16. (a) Informant Ralph Snider

(b) Address Boonville, Mo.

17. (a) Burial (b) Date thereof May 11 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove Cem.

18. (a) Signature of funeral director Goodman & Boller.

(b) Address Boonville, Mo.

19. (a) 5-10-47 (b) De Cooper  
(Date received local registrar) (Registrar's signature)

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 T. C. Beckett M.D. (M.D. or other)

Address Boonville, Mo. Date signed 5-10-47

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5-29-47

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.....

*J. H. Goodman*

Licensed Embalmer No. 1178

P. O. Address.....

*Beauville, 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.