

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23897**
Registrar's No. **74**

FILED AUG 9 1947

Registration District No. **20**

Primary Registration District No. **5444**

1. PLACE OF DEATH:

(a) County **Kentucky**
(b) City or town **Albany Rural Athens Township**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7 miles E & S of Albany 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **40 years** years, months or days

3. (a) PRINT FULL NAME **Minerva Simpson Snow**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W**
(b) Name of husband or wife **James Snow Deceased** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept 3 1874** (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
72 10 10 hr. min.

9. Birthplace **Kentucky County MO** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
12. Name **Seth J. Posey**
13. Birthplace **Kentucky** (City, town, or county) (State or foreign country)
14. Maiden name **Marquie Boyd**
15. Birthplace **Kentucky** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ray Hill**

(b) Address **Albany MO**

17. (a) **Burial** (b) Date thereof **July 15 1947** (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Foster Cemetery**

18. (a) Signature of funeral director **W. H. Noble**

(b) Address **New Hanover MO**

19. **Aug 1 1947** (b) **Thomas H. Mabe** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Kentucky 38**
(c) City or town **Rural Athens Township**
(If outside city or town limits, write "RURAL")
(d) Street No. **7 miles S.E. of Albany** (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **13** year **1947** hour **4** minute **45** P.M.

21. I hereby certify that I attended the deceased from **July 8**, 1947, to **July 13**, 1947, that I last saw her alive on **July 12**, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage** Duration **2 Days**

Due to **Hypertension**

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 **J. S. Harding** (M.D. or other) **DO**
Address **Albany Mo.** Date **July 14 1947**

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed W. B. Noble

Licensed Embalmer No. 2904

P. O. Address New Hampton

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.