

S. No. 2
DM-5-43
v. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30645**

FILED SEP 22 1947
55

Registration District No. _____

Primary Registration District No. **3011**

Registrar's No. **231**

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

1. PLACE OF DEATH:

(a) County **Carroll**

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

(c) Name of hospital or institution: **203 So. Folger**
(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 **Entire Life** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Carroll**

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

(d) Street No. **203 So. Folger**
(If rural, give location)

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

3. (a) PRINT FULL NAME **AMOS BEDFORD SNIDER**

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

4. Sex **Mo** 5. Color **W** 6. (a) Single, widowed, married, divorced **Married**

7. (b) Name of husband or wife **Ruby Williams Snider** 7. (c) Age of husband or wife if alive **57** years

8. Birth date of deceased **June 1 1889**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
58	3	3	_____ min.

9. Birthplace **Carroll Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **Amos Snider**

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

14. Maiden name **Matilda Mattox**

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

16. (a) Informant **Mrs. Amos B. Snider**
(b) Address **Carrollton Mo.**

17. (a) Burial (b) Date thereof **9-6-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fairhaven Cem. Standley Gibson**

18. (a) Signature of funeral director **Carrollton Mo.**
(b) Address _____

19. (a) 9/5/47 (b) **Mr. Herbert Calish**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **4** year **1947** hour **5** minute **20 A.M.**

21. I hereby certify that I attended the deceased from **9/1/47** to **9/4/47**, 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**

Due to **3920**

Due to _____

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

Major findings:
Of operations _____

Of autopsy **93E**

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? _____

(Specify type of place) _____ (2) Means of injury _____

23. Signature **Reggie Dean** (M. D. or other) _____

Address **Carrollton** Date signed **9-5-47**

RECEIVED

District Health Officer No: 8

District File Number ~~.....~~

Date Filed 9-18-47

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 Ben W. Gibson

Licensed Embalmer No. 2961

P. O. Address Carrollton, 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.