

No. 2
-12-45
5-17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34684**
Registar's No. **4332**

FILED OCT 25 1947
Registration District No. **2407**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 hrs
 In this community 70 yrs
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME Dora Snyder

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Wid 2

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive 4 years

7. Birth date of deceased Aug 5 1870
 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>82</u>	<u>5</u>	hr. min.

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER

12. Name Patton France

13. Birthplace no record
 (City, town, or county) (State or foreign country)

14. Maiden name no record

15. Birthplace no record
 (City, town, or county) (State or foreign country)

16. (a) Informant Mr. Jack C Snyder

(b) Address Res. Angelo Calif

17. (a) Burial (b) Date thereof Oct 14 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Mr C R Foster

(b) Address 918 Brooklyn

19. (a) 10-14-47 (b) Albaldine Holmes
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 703 - East - 14th St.
 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10
 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from June 6 1947 to Oct 10 1947
 that I last saw her alive on Oct 10 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive heart disease

Due to Generalized arterio-sclerosis

Duration
5 years
10 years

Due to _____

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

Major findings: 93A

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:

(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) _____

(b) Means of injury _____

23. Signature Nabat Shurey (M. D. or other) M.D.
 Address 3903 Brooklyn Date signed 10-11-47

Dr. Shuey

3903
& Brooklyn

Wa 6493

2-5
S. A. M. Max

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.....

Cortland Minou
3414

Licensed Embalmer No.....

P. O. Address.....
918 Brooklyn

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.