

Registration District No. **1**

Primary Registration District No. **3000**

1. PLACE OF DEATH:

(a) County **Adair county**
(b) City or town **Kirksville, Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Laughlin hospital**
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution **8 days**
(Specify whether
In this community **Entire life**
years, months or days)

3. (a) PRINT FULL NAME **Elma Yancey Snider**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Hazel Snider** 6. (c) Age of husband or wife if alive **46** years
7. Birth date of deceased **June 16th 1893**
(Month) (Day) (Year)

8. AGE: Years **54** Months **5** Days **11** If less than one day
hr. min.

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

10. Usual occupation **Farming**

11. Industry or business **F**

12. Name **Joseph Snider**

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

14. Maiden name **Mary Jane Blackburn**

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

16. (a) Informant **Mrs. Hazel Snider**

(b) Address **Lakenand Mo.**

17. (a) **Burial** (b) Date thereof **11-29-1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kendal cemetery**

18. (a) Signature of funeral director **Million & Barkelew**
Shelbina, Mo.

(b) Address **11-29-47** **Kate Sambert**

19. (a) **11-29-47** (b) **Kate Sambert**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Shelby**
(c) City or town **Kendal Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **No.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **26th**
year **1947** hour **8** minute **15 P.M.**

21. I hereby certify that I attended the deceased from **Nov. 23**, 19**47**, to **Nov. 26**, 19**47**
that I last saw him alive on **Nov 26**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage (hyp 5 hrs**

Due to **Hypertensive Heart Disease with Decompensation** **mos.**

Due to **Chronic Nephritis** **Yes.**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **731/8**

Of autopsy

Underline the cause of 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)

(e) Means of injury **1**

23. Signature **W. M. Cline** (M. D. or other) **DO**

Address **Kirksville Mo** Date signed **11/27/47**

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

MOTHER FATHER

JAN 23 1958

RECEIVED
District Health Officer No. 10
District File Number 12-47-1682
Date Filed DEC 1 0 1947

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 _____

James D. Davis, Registered Apprentice No. 443
working under my personal supervision.

Signed _____

Licensed Embalmer No. 3498

P. O. Address Shelburne 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.