

FILED DEC 29 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42145**

Registration District No. **12 4**

Primary Registration District No. **5601**

Registrar's No. **136**

1. PLACE OF DEATH:

(a) County Johnson.
(b) City or town rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: County Home 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 Mo. (Specify whether
In this community 13 Mo. years, months or days)

3. (a) PRINT FULL NAME Thomas S. Snedegar.

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced don't know. 9

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

7. Birth date of deceased April. 14, 1865
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>82</u>		<u>8</u>	<u>4</u>hr.min.

9. Birthplace unknown KY.
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business.....

12. Name Moses Snedegar

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

14. Maiden name Joan Campbell

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

16. (a) Informant Ward Hathaway. County Home

(b) Address Superintendent. Warrensburg.

17. (a) Burial (b) Date thereof 12/20/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia, Tenn.

18. (a) Signature of funeral director Sweeney Phillips.

(b) Address Warrensburg, Mo.

19. (a) Dec. 18, 1947 (b) Sarah M. Dentfield 23. Signature W. R. Phillips (Date received local registrar) (Registrar's signature) (Date) Address Warrensburg Date signed 12-18-47

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson. 57
(c) City or town R. F. D. Warrensburg
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 18
year 1947 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from
untill body after death
that I last saw h..... alive on....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death from trauma Duration
Death was shock

Due to Fall from second
story window
Due to accidental

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

Major findings:
Of operations.....

Of autopsy no 1918 A
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)..... 57
(b) Date of occurrence Dec 18 1947
(c) Where did injury occur? at County Home
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0

While at work? no (Specify type of place) (e) Means of injury.....

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

MOTHER FATHER

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.....

W. Jack Phillips , Registered Apprentice No. *14*
working under my personal supervision.

Signed *R. A. Phillips*

Licensed Embalmer No. *2320*

P. O. Address *Warrensburg, 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.

No. 2
1 X 43800

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42145-
State File No. gan
Registrar's No. 2

Registration District No. 164

Primary Registration District No. 5601

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Thomas S. Snedegar
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced D.K.

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April (Month) 1 (Day) 1942 (Year)

8. AGE: Years 82 Months _____ Day _____ (less than one day) _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April 1942 year, 1 hour, 8 minute M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

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 _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

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

