

FILED JUN 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

15154

State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>52</u>		PRIMARY REG. DIST. NO. <u>3009</u>		Registrar's No. <u>45</u>	
1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Jackson</u>		c. LENGTH OF STAY (in this place) <u>30 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Jackson</u>		2	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>11 High St.</u>				d. STREET ADDRESS (If rural, give location) <u>11 High St.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>George</u>		b. (Middle) <u>Lee</u>		c. (Last) <u>Snider</u>	
4. DATE OF DEATH		(Month) <u>May</u>		(Day) <u>31</u>		(Year) <u>1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED; WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 18, 1868</u>	9. AGE (In years last birthday) <u>81</u>	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 1 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Fruitland Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Logan Snider</u>		13b. MOTHER'S MAIDEN NAME <u>Narcisus McCombs</u>		14. NAME OF HUSBAND OR WIFE <u>Anna Snider</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>490-18-6755</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Anna M. Snider</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Decompensation</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Senility</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>47</u> , to <u>May 31</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>49</u> , and that death occurred at <u>12:30 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Ed McDonald, M.D.</u>				23b. ADDRESS <u>Jackson, Mo.</u>		23c. DATE SIGNED <u>6-8-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-1-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CITY</u>		24d. LOCATION (City, town, or county) (State) <u>Jackson Mo.</u>	
DATE REC'D BY LOCAL REG. <u>June 4, 1949</u>		REGISTRAR'S SIGNATURE <u>Ed McDonald</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Cheracraft</u>			
				ADDRESS <u>Jackson Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 649-266

Date Filed 6-6-49

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Lester C. Craight

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.