

FILED JUN 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18808**
Registrar's No. **205**

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

BIRTH NO. _____ REG. DIST. NO. **47** PRIMARY REG. DIST. NO. **3008**

1. PLACE OF DEATH a. COUNTY Hallaway		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY MONROE	
b. CITY OR TOWN Fulton	c. LENGTH OF STAY (In this place) 22	c. CITY OR TOWN Paris, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital #1 Fulton		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)
a. (First) **Robert** b. (Middle) **Snell** c. (Last) **Snell**

4. DATE OF DEATH (Month) (Day) (Year)
June 10 49

5. SEX **M** 6. COLOR OR RACE **W** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **Sept. 14, 1888** 9. AGE (In years last birthday) **60**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Farmer**

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Monroe County, Missouri**

12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **D K** 13b. MOTHER'S MAIDEN NAME **Maddie M. McMan** 14. NAME OF HUSBAND OR WIFE **Mrs. Robert Snell**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **DK**

16. SOCIAL SECURITY NO. **DK**

17. INFORMANT'S SIGNATURE OR NAME **Hospital Record** ADDRESS **Fulton**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Pulmonary Tuberculosis**

ANTECEDENT CAUSES

*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

II. OTHER SIGNIFICANT CONDITIONS

CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH **002X**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

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) (Min.)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 1, 1949**, to **June 10, 1949**, that I last saw the deceased alive on **June 9, 1949**, and that death occurred at **2:20 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **M J Miller** 23b. ADDRESS **State Hospital, Fulton, Mo** 23c. DATE SIGNED **6-10-49**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **June-12-1949** 24c. NAME OF CEMETERY OR CREMATORY **Paris Mo** 24d. LOCATION (City, town, or county) (State) **Paris Mo**

DATE REC'D BY LOCAL REG. **June-10-1949** REGISTRAR'S SIGNATURE **Maretha Lawrence** 426

25. FUNERAL DIRECTOR'S SIGNATURE **Spencer Blodgett** ADDRESS **Paris, Mo**

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 16 1949

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.

Signed *E. H. [Signature]*

Signed _____
Student Embalmer

Licensed Embalmer No. 4000

P. O. Address Pavia, 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.