

FILED JUL 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **23813**

BIRTH NO. _____		REG. DIST. NO. <u>150</u>		PRIMARY REG. DIST. NO. <u>5572</u>		Registrar's No. <u>117</u>	
1. PLACE OF DEATH a. COUNTY <u>Sebastian</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write BUREAU and give township) <u>Sebastian</u>		c. LENGTH OF STAY (In this place) <u>2 da</u>		c. CITY (If outside corporate limits, write BUREAU and give township) <u>7520 E. New 40th</u>		d. STREET ADDRESS (If rural, give location) <u>Emergency Dept D</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>Merlin</u> c. (Last) <u>Snyder</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 30 49</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>		8. DATE OF BIRTH <u>June 21 1872</u>	
9. AGE (In years last birthday) <u>76</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>O.A.P.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.A.P.</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland Co. Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Charles Snyder</u>		13b. MOTHER'S MAIDEN NAME <u>Theresa Matilda</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Opal F. Snyder</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Opal F. Snyder</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>Uremia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic nephritis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Transition</u>				INTERVAL BETWEEN ONSET AND DEATH <u>59 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>?</u>				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 checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 18</u> to <u>June 19</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>June 19</u> , and that death occurred at <u>1:30</u> p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Frank B. Johnson, M.D.</u>				23b. ADDRESS <u>Indep. Mo</u>		23c. DATE SIGNED <u>6/30/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-2-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Edgewood Cem</u>		24d. LOCATION (City, town, or county) (State) <u>Chillicothe Mo</u>	
DATE REC'D BY LOCAL REG. <u>JULY 2, 1949</u>		REGISTRAR'S SIGNATURE <u>Ronald C. Emswiler</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wilton K. Pepler</u>			
						ADDRESS <u>Indep. Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

JUL 19 RECD

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

Dixon L. Taylor
4225

Licensed Embalmer No. _____

P. O. Address *Indep. Md*

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.