

FILED JUN 14 1950

THE DIVISION OF HEALTH OF MISSOURI Dr. Huffman  
STANDARD CERTIFICATE OF DEATHR.R. 16522  
State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>5460</u>		Registrar's No. <u>527</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Rural Clay Township</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Clay Township</u>		d. STREET ADDRESS (If rural, give location) <u>Route # 2 Rogersville, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Route # 2 Rogersville, Mo.</u>				d. STREET ADDRESS (If rural, give location) <u>Route # 2 Rogersville, Mo.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Walker</u> c. (Last) <u>Snow</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 6, 1950</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>March 22, 1875</u>	9. AGE (In years last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Greene County Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>John Snow</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Jane Lee</u>		14. NAME OF HUSBAND OR WIFE <u>Lou Wallace Snow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>?</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Ellis Galloway Rt#2 Rogersville, Mo.</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>Hypertensive arteriosclerosis heart disease.</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4/20/50</u>					INTERVAL BETWEEN ONSET AND DEATH _____	
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) (Min.) _____	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>4-10</u> 1950, to <u>6-4</u> 1950, that I last saw the deceased alive on <u>6-4</u> 1950, and that death occurred at <u>11 a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. R. Huffman M.D.</u>			23b. ADDRESS <u>Springfield, Mo.</u>		23c. DATE SIGNED <u>6-6-50</u>		
24a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/8/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Dodson Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Near Rogersville, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>6-9-50</u>	REGISTRAR'S SIGNATURE <u>W. E. Handley M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>H. H. Lohmeyer Springfield, Mo.</u>					

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**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.