

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **8202**

FILED APR 12 1954

BIRTH NO. _____ REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 486 Registrar's No. 15

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY FRANKLIN | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN | |
| c. LENGTH OF STAY (in this place) 20 YRS | | d. STREET ADDRESS (If rural, give location) R. R. # 2 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION NORTHSIDE HOSPITAL | | | |

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|---|--|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) JANE b. (Middle) JOSEPHINE c. (Last) SNYDER | | | 4. DATE OF DEATH (Month) (Day) (Year) APRIL 6, 1954 | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | |
| 8. DATE OF BIRTH 1866 MAY 11, 1864 | | 9. AGE (In years last birthday) 87 | | 10. USUAL OCCUPATION (His kind of work during most of working life, even if retired) HOUSEWIFE | |
| 11. BIRTHPLACE (State or foreign country) HENDERSON KENTUCKY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 10b. KIND OF BUSINESS OR INDUSTRY None | |

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|---|--|---|--|---|--|
| 13a. FATHER'S NAME JAMES RYAN | | 13b. MOTHER'S MAIDEN NAME HARRIET McDOWELL | | 14. NAME OF HUSBAND OR WIFE JOHN SNYDER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT'S SIGNATURE OR NAME MRS. JOHN MOHANY ADDRESS SULLIVAN, MO | |

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|---|--|---|--|--|--|
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration Pneumonia | | | INTERVAL BETWEEN ONSET AND DEATH 1 Day |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Abdominal Distention | | | E9030 20 2 days |
| | | DUE TO (c) Fractured R. Left Femur | | | 3 3 days |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Card. - Vascular Disease Years. | | | |

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|-----------------------------------|--|----------------------------------|--|--|--|
| 19. DATE OF OPERATION None | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
|-----------------------------------|--|----------------------------------|--|--|--|

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|--|--|---|--|--|--|
| 21a. ACCIDENT (Specify) Fractured Hip | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Franklin Missouri | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) April 4 1954 4 PM | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? Injured while walking in house. | |

22. I hereby certify that I attended the deceased from **Nov. 1953**, to **April 6, 1954**, that I last saw the deceased alive on **April 6, 1954**, and that death occurred at **1:30 p.m.**, from the causes and on the date stated above.

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|---|--|--|--|--|--|
| 23a. SIGNATURE (Degree or title) Robert D. Crawford M.D. | | 23b. ADDRESS Sullivan Mo. | | 23c. DATE SIGNED April 7, 1954 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE APRIL 9, 1954 | | 24c. NAME OF CEMETERY OR CREMATORY ANCONDA CEMETERY | |
| 24d. LOCATION (City, town, or county) (State) ANCONDA MISSOURI | | DATE REC'D BY LOCAL REG. 4/8/54 | | REGISTRAR'S SIGNATURE Thomas A. Humphrey | |
| FUNERAL DIRECTOR'S SIGNATURE Wm. Eaton | | ADDRESS Sullivan Mo. | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48
361
0

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 Thomas A. Humphrey

Licensed Embalmer No. 4772

P. O. Address Sullivan, 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.