

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14778**

FILED MAY 26 1954

BIRTH NO. **28111-54** REG. DIST. NO. **1** PRIMARY REG. DIST. NO. **3000** Registrar's No. **127**

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY SCHUYLER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirksville	c. LENGTH OF STAY (In this place) 9 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Queen City 0 480	
d. FULL NAME OF HOSPITAL OR INSTITUTION Kirkville Osteopathic Hosp.		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Daniel c. (Last) Snider	4. DATE OF DEATH (Month) (Day) (Year) 5-15-54					
5. SEX M	6. COLOR OR RACE W	7. MARRIED NEVER MARRIED, WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH 5-6-54	9. AGE (In years last birthday) 9	IF UNDER 1 YEAR Months 9	IF UNDER 12 HRS. Hours 9 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME Clifford Cecil Snider	13b. MOTHER'S MAIDEN NAME Lola Mae Wheeler	14. NAME OF HUSBAND OR WIFE —
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME Lola Mae Snider ADDRESS Queen City
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure		INTERVAL BETWEEN ONSET AND DEATH 1 day
	ANTECEDENT CAUSES DUE TO (b) Hypoxia protracta		9 days
	DUE TO (c) Prolonged birth delivery		9 days
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Convulsions			9 days

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 7620
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) —	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 **5/6** **1954**, to **5/15** **1954**, that I last saw the deceased alive on **5/15** **1954**, and that death occurred at **6:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Print or title) Edward M. Roberts, M.D.	23b. ADDRESS Queen City, Mo	23c. DATE SIGNED 5/17/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 16 '54	24c. NAME OF CEMETERY OR CREMATORY Queen City Cemetery	24d. LOCATION (City, town, or county) (State) Queen City, Mo
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DATE REC'D BY LOCAL REG. 5-19-54	REGISTRAR'S SIGNATURE Hate Lambert 1-0	25. FUNERAL DIRECTOR'S SIGNATURE Dooley Inal Home ADDRESS Queen City
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Jack Woolley
Licensed Embalmer No. 4619

P. O. Address Queen City, 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.