

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

State File No. **15213**  
Registrar's No. **82**

**FILED MAY 25 1954**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **59** PRIMARY REG. DIST. NO. **4093**

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

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cass</b>  b. CITY (If outside corporate limits, write RURAL and give town or township) <b>East Lynne, Mo.</b> c. LENGTH OF STAY (in this place) <b>47 years</b> d. FULL NAME OF HOSPITAL OR INSTITUTION <b>On Railroad track</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cass</b>  c. CITY (If outside corporate limits, write RURAL and give township) <b>Rural Index township</b> d. STREET ADDRESS (If rural, give location) <b>Latour RR#2</b>		
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Willie</b> b. (Middle) <b>Tim</b> c. (Last) <b>Snow</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>May 20 1954</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Sept. 12, 1882</b>	<b>9. AGE</b> (In years last birthday) <b>71</b> IF UNDER 1 YEAR: Months <b>8</b> Days <b>8</b> IF UNDER 10 Min. Hours _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Railroad Section Foreman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>Cumberland Gap Kentucky</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>
<b>13a. FATHER'S NAME</b> <b>Leo Snow</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>Martha Jane Williams</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Ruth Snow</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>702-10-8310</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <b>Mrs. Ruth Snow, Latour, Mo. RR #2</b>	
<b>18. CAUSE OF DEATH</b> 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.		<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>30 minutes</b>
		<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>CORONARY Thrombosis</b>  <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b>  DUE TO (c) _____		<b>UNICROWN</b>
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) <input checked="" type="checkbox"/>		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <b>Latour (Cass) Missouri</b>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____		<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>3 P</b> m., from the causes and on the date stated above.</b>				
<b>23a. SIGNATURE</b> (Degree or title) <b>Dr. J. G. Gargner, M.D.</b>		<b>23b. ADDRESS</b> <b>Harrisonville, Mo.</b>		<b>23c. DATE SIGNED</b> <b>21 MAY 54</b>
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>24b. DATE</b> <b>May 22, 1954</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>Gunn City Cemetery</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>Gunn City, Missouri</b>	
<b>DATE REC'D BY LOCAL REG.</b> <b>May 22, 1954</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Nora Bernard</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <b>W. H. Harrison, Harrisonville, Mo.</b>	

1954  
MAY 22

MOC

RECEIVED  
MAY 22 1954  
CASS COUNTY  
HEALTH DEPARTMENT

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 *Robert W. Atkinson*

Licensed Embalmer No. *4902*

P. O. Address *Hammock, 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.