

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25404

State File No.

FILED AUG 29 1955

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 923

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Joseph)		c. LENGTH OF STAY (in this place township) 50 Yrs	c. CITY OR TOWN St. Joseph
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		f. STREET ADDRESS (If rural, give location) 2820 Edmond St.	

3. NAME OF DECEASED (Type or Print) a. (First) Clarence	b. (Middle) W.	c. (Last) Snodgrass	4. DATE OF DEATH (Month) (Day) (Year) Aug. 21, 1955
---	-----------------------	----------------------------	---

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 2, 1906	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
--------------------	-------------------------------	---	-------------------------------------	---	-----------------------------	-----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaner & Presser	10b. KIND OF BUSINESS OR INDUSTRY Ret. Dry Cleaning	11. BIRTHPLACE (City and State or Foreign Country) Leona, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Ollis P. Snodgrass	13b. MOTHER'S MAIDEN NAME Minnie Roberts	14. NAME OF HUSBAND OR WIFE Sophia Snodgrass
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 491-09-6150	17. INFORMANT'S SIGNATURE OR NAME Mrs C.W. Snodgrass	ADDRESS 2820 Edmond St. City
--	--	---	-------------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH 5 mo
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gen. Carcinoma		
	ANTECEDENT CAUSES Morbid 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.		1949	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Biopsy of Bladder + Neck - Carcinoma	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	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 March 23, 1955, to Aug 21, 1955, that I last saw the deceased live on Aug 20, 1955, and that death occurred at 7:00a m., from the causes and on the date stated above.

23a. SIGNATURE L. T. Matherhead (Degree or title) M D O	23b. ADDRESS 2603 Fredrick Ave., City	23c. DATE SIGNED 23 Aug 55
---	--	-----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Aug. 24, 55	24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
---	------------------------------	---	--

DATE REC'D BY LOCAL REG. Aug 25, 1955	REGISTRAR'S SIGNATURE Kathleen M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE Vermon W. Sideman	ADDRESS St. Joseph, Mo.
--	--	---	--------------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

10.300
0.48

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.....
Signature of Student Embalmer

Signed..... *Robert H. Gable*

Licensed Embalmer No. 3308

P. O. Address St. Joseph,

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.