

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-008660

STATE FILE NUMBER

FILED APR 7 1959

Registration District No.

53

Primary Registration District No.

0000

Registrar's No.

114

1. PLACE OF DEATH a. COUNTY Cape Girardeau		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jackson		c. CITY OR TOWN Jackson <i>c160</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Route 4		d. STREET ADDRESS (If outside, give location) Route 4	
3. NAME OF DECEASED (Type or print) First Anthony Middle N. Last Snider		4. DATE OF DEATH Month March Day 27 Year 1959	
5. SEX Male <i>2</i>	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1901
10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (City and state or country) Jackson, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME John Q. Adams Snider		13b. MOTHER'S MAIDEN NAME Mahalia (Unknown)	
14. NAME OF HUSBAND OR WIFE Alma Snider		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 498-03-8315		17. INFORMANT Address Alma Snider, Rt. 4, Jackson, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4344		INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 2-12-54 to 3-27-59 and last saw him alive on 3-14-59 Death occurred at 11:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE E. J. McDonnell, M.D. (Degree or title)	
22b. ADDRESS Jackson, Mo.		22c. DATE SIGNED 3-31-59	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE April 2, 1959	
23c. NAME OF CEMETERY OR CREMATORY Russell Heights		23d. LOCATION (City, town, or county) (State) Jackson, Mo.	
24. FUNERAL DIRECTOR L. R. Sparks		25. DATE RECD. BY LOCAL REG. 4-2-59	
26. REGISTRAR'S SIGNATURE Lucene Hester			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no diseases in Part I must be causally related.

APR 8 1959

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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
Signature of Student Embalmer

Signed Edward A. Ruffin

Licensed Embalmer No. 5022

P. O. Address Chapel Hill, N.C.

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.