

59-036921

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

FILED VS NOV 3 1959

 Registration District No. 210 Primary Registration District No. \_\_\_\_\_ Registrar's No. 54

 Dept. Health,  
duc., & Welfare  
U. S. Public  
Health Service

 V. S. 300  
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <b>Mercer</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Mercer</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mercer</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Mercer</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Own Home</b>		Length of stay in lb <b>2 years</b>	d. STREET ADDRESS (If outside, give location) <b>450</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>Andrew</b> Last <b>Snyder</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>20,</b> Year <b>1959</b>		
5. SEX <b>Male</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1876</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (City and state or country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Wilson Snyder</b>		13b. MOTHER'S MAIDEN NAME <b>Ellen Grubb</b>		14. NAME OF HUSBAND OR WIFE <b>Gertie Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input type="checkbox"/> or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Laura L. Shaffer</b> Address <b>Mercer, Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis</b>					<b>10 years</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) <b>4 sac</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <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 <b>4-6-1957</b> to <b>10-20-59</b> and last saw her/him alive on <b>10-6-59</b> Death occurred at <b>2-30 p.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Douglas J. Pierce, D.O.</b>			22b. ADDRESS <b>Princeton, Mo.</b>		22c. DATE SIGNED <b>10-28-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 22, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Girdner Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mercer County Mo.</b>
24. FUNERAL DIRECTOR <b>Paul Shaffer</b>		ADDRESS <b>Lineville Iowa</b>		25. DATE RECD. BY LOCAL REG. <b>10-28-59</b>	26. REGISTRAR'S SIGNATURE <b>Dore Moss</b>

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MO RS 1949.

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

3930

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, ~~as by~~ ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed

*James L. Greenlee*

Licensed Embalmer No. *3967*.....

P. O. Address *Louisville, Ky.*.....

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.