

JURI DIVISION - HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 11 1960

'59 04 3 2 1 6

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 397

ENDED

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|---------------------------------------|--|--|----------------|--|
| 1. PLACE OF DEATH a. COUNTY Adair | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan | | | | | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkville | | Length of stay in 1b 17 days | | c. CITY OR TOWN Green Castle | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kirkville Osteopathic Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 2 mi. South East | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Glenn Middle Roy Last Snyder | | | | 4. DATE OF DEATH Month Dec. Day 29 Year 1959 | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 7/19/1892 | | 9. AGE (last birthday) 67 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming | | 11. BIRTHPLACE (City and state or country) Green Castle, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | | | | | |
| 13a. FATHER'S NAME John H. Snyder | | | | 13b. MOTHER'S MAIDEN NAME Arrena Muir | | | | 14. NAME OF HUSBAND OR WIFE Rosa Snyder | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 493-42-4977 | | 17. INFORMANT Address Mrs. Rosa Snyder, Green Castle, 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) Meningitis DUE TO (b) Pneumonia DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH about 3 wks about 4 wks | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) arteriosclerosis (generalized) | | | | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ 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 Dec 12, 1959 to Dec 29, 1959 and last saw him alive on Dec 29, 1959 Death occurred at 11: 18 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Richard H. Turner D.O. | | | | | | 22b. ADDRESS Kirksville, Mo | | | 22c. DATE SIGNED 12/30/1959 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/1/1960 | | 23c. NAME OF CEMETERY OR CREMATORY Green Castle Cemetery | | 23d. LOCATION (City, town, or county) Green Castle, Mo. | | (State) | | | | | |
| 24. FUNERAL DIRECTOR Glenn E. Kent & Son, Green City, Mo. | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. 1-4-1960 | | 26. REGISTRAR'S SIGNATURE Doris W. Ratliff | | | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 13 1962

RICHARD H. TURNER, D.D.

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 Karl R. Kent

Licensed Embalmer No. 4688
P. O. Address Green 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.