

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 3 1960

-60-026219

STATE FILE NUMBER

Registration District No. 70 Primary Registration District No. _____ Registrar's No. 50

1. PLACE OF DEATH a. COUNTY <u>Clark</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clark</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lincoln Township.</u>		Length of stay in 1b <u>life</u>	c. CITY OR TOWN <u>Luray</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rural</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Julia May Snider</u>			4. DATE OF DEATH Month Day Year <u>7 15 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-1868</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	11. BIRTHPLACE (City and state or country) <u>Clark Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13. FATHER'S NAME <u>Isaac Snider</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Boley</u>		14. NAME OF HUSBAND OR WIFE <u>W</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>496-40-8147</u>	17. INFORMANT <u>Miss Elizabeth Snider, Luray, Mo.</u> address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Myocardial Insufficiency</u>	<u>at once</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Pneumonia</u>	<u>Jan. 1960</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	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
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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 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 1950 to June 15th and last saw her/him alive on June 30th on the date stated above, and to the best of my knowledge, from the causes stated. Death occurred at _____

22a. SIGNATURE (Degree or title) <u>Grace L Gray M.D.</u>	22b. ADDRESS <u>Kahoka, Mo.</u>	22c. DATE SIGNED <u>6-16-'60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 17, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashton Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Ashton, Clark Co Mo</u>
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24. FUNERAL DIRECTOR <u>Walter Luttinger</u> ADDRESS <u>Kahoka Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-29-60</u>	26. REGISTRAR'S SIGNATURE <u>J. W. Bonczerski</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 11 1960

APR 6 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Oliver S. Suttus

Licensed Embalmer No. 2960

P. O. Address Franklin

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.