

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-035512

LED VS OCT 13 1960

209

Primary Registration District No. 3043

Registrar's No. 396

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Marion</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Marion</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Length of stay in 1b <b>1 yr</b>		c. CITY OR TOWN <b>Hannibal</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>2005 Market St</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2005 Market St</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Raymond</b> Last <b>Snodgrass</b>				4. DATE OF DEATH Month <b>10</b> - Day <b>1</b> - Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-15-86</b>		9. AGE (last birthday) <b>74</b>		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) <b>Brick Mason</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Ralls County, Mo.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>				
13a. FATHER'S NAME <b>William H. Snodgrass</b>				13b. MOTHER'S MAIDEN NAME <b>Sarah R. Dyer</b>				14. NAME OF HUSBAND OR WIFE <b>Nell Snodgrass</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>490-07-9045</b>		17. INFORMANT Address <b>Riter Snodgrass - Hannibal, 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>Acute Myocardial Decompensation</b>										INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>cardiorrenal syndrome with edema</b>										<b>2 to 3 yrs</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>Prostatic hypertrophy and inflammation</b>								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 type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/>		20b. SUICIDE <input type="checkbox"/>		20c. HOMICIDE <input type="checkbox"/>		20d. 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 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 <b>Feb 19 1960</b> to <b>10/1/60</b> and last saw him alive on <b>10/1/60</b> Death occurred at <b>11:50 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>Sam A. Buchanan P.O.</b>						22b. ADDRESS <b>1001 Broadway Hannibal Mo.</b>			22c. DATE SIGNED <b>10/4/60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-4-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hydsburg Gemetery</b>			23d. LOCATION (City, town) or county <b>Hannibal, Mo.</b>			23e. STATE <b>Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Clark Funeral Home - Hannibal, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>10/7/60</b>		26. REGISTRAR'S SIGNATURE <b>Dr. E. M. Rusche by Lillian M. Norman</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Ralph Clark*

Licensed Embalmer No. 4217

P. O. Address Hannibal, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.