

AMENDED

Registration District No. 316 Primary Registration District No. Registrar's No. 287

STATE FILE NUMBER

FILED AUG 1 1961

1. PLACE OF DEATH a. COUNTY ST FRANCOIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST FRANCOIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN FARMINGTON MO. - RURAL		c. CITY OR TOWN FARMINGTON	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION THOMAS DELL HOME		d. STREET ADDRESS (If outside, give location)	

3. NAME OF DECEASED (Type or print) GEORGE LEE SNELSON			4. DATE OF DEATH JULY 21 1961	
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/15/92	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) BISMARCK MO	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME ISAAC SNELSON	13b. MOTHER'S MAIDEN NAME SARAH PINELL	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	17. INFORMANT MRS. AUDREY NOSSETT FARMINGTON MO.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition + Debilitation		INTERVAL BETWEEN ONSET AND DEATH 1mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Gastric Dumping Syndrome	6mo.
	DUE TO (c) Gastric Ulcer	3yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic emphysema	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.)
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20c. TIME OF INJURY Hour 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
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21. I attended the deceased from 1955 to 7-21-61 and last saw ^{her} him alive on 7-21-61 Death occurred at 3:55 pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M. C. Cozear (Deceased or title)	22b. ADDRESS Farmington Mo.	22c. DATE SIGNED 7-28-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 7/24/61	23c. NAME OF CEMETERY OR CREMATORY MASONIC	23d. LOCATION (City, town, or county) DOE RUN MISSOURI
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24. FUNERAL DIRECTOR C.H. COZEAN FARMINGTON MO.	25. DATE RECD. BY LOCAL REG. July 24 1961	26. REGISTRAR'S SIGNATURE Ether Redloff
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
W. Cozear

Licensed Embalmer No. HOB

P. O. Address Farmington

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.