

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-031721**

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 284

AMENDED

**FILED OCT 9 1961**

DATE AMENDED

1. PLACE OF DEATH a. COUNTY <b>Adair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Adair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirksville</b>	Length of stay in 1b <b>5 days</b>	c. CITY OR TOWN <b>Novinger</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Kirksville Osteo. Hosp.</b>		d. STREET ADDRESS (If outside, give location) <b>R.F.D.# 1</b>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>EDWIN</b> Last <b>SNYDER</b>			4. DATE OF DEATH Month <b>September</b> Day <b>29</b> Year <b>1961</b>		
5. SEX <b>male</b>	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>5/20/1898</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>9</b> Hours <b></b> Min. <b></b>
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>farming</b>	11. BIRTHPLACE (City and state or country) <b>Adair Co., Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Susie Darr</b>		14. NAME OF HUSBAND OR WIFE <b>Ada Slover</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>	17. INFORMANT <b>Mrs. Ada Snyder-Novinger, Mo.</b>	Address <b></b>
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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) <b>Pulmonary Infarct.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 Minutes</b>
DUE TO (b) <b>Arteriosclerosis Heart Disease.</b>		<b>Unknown</b>
DUE TO (c) <b></b>		<b></b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Repair of bilateral inguinal hernia, 3rd P. O Day</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
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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.) <b></b>
20c. TIME OF INJURY Hour <b></b> a.m. <b></b> p.m. <b></b>	Month, Day, Year <b></b>	

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.) <b></b>	20f. CITY, TOWN, OR LOCATION <b></b>	COUNTY <b></b>	STATE <b></b>
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21. I attended the deceased from **9-26-61** to **9-29-61** and last saw him alive on **9-29-61**,  
Death occurred at **3:05 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Russ B. Thompson MD</b>	22b. ADDRESS <b>800 W Jefferson, Kirksville</b>	22c. DATE SIGNED <b>10-2-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>10-3-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Salisbury Centry</b>
23d. LOCATION (City, town, or county) <b>Adair County, Mo.</b>		(State)

24. FUNERAL DIRECTOR <b>Dee Riley Funeral Home, Inc.</b> 415 North Franklin <b>Kirksville, Missouri</b>	ADDRESS <b>W.K. Jackson, Pres.</b>	25. DATE RECD. BY LOCAL REG. <b>10-5-1961</b>	26. REGISTRAR'S SIGNATURE <b>Doris W. Ratliff</b>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MAY 24 1962

Ross B. THOMPSON, D.O.

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 Kenneth E. Hayes

Licensed Embalmer No. 4896

P. O. Address Kirkville, 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.