

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-032144

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

FILED OCT 9 1961

1. PLACE OF DEATH

a. COUNTY Cape

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN Cape Girardeau

Length of stay in 1b

5 hrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY Stoddard

c. CITY

OR TOWN

Idalia

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR

INSTITUTION

St. Francis Hosp.

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

ADDRESS

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)

First

Am

Middle

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Last

SNIDER

4. DATE OF DEATH

Month

Day

Year

October 1, 1961

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

Aug. 22-92

9. AGE (last birthday)

69

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY

crop farming

11. BIRTHPLACE (City and state or country)

Avert, Missouri

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Johan A. Snider

13b. MOTHER'S MAIDEN NAME

Nancy Robey

14. NAME OF HUSBAND OR WIFE

Addie Snider

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

702 18 7890

17. INFORMANT

Address

Mrs. Am Snider, Idalia, Missouri

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Cerebral Hemorrhage acute

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Arteriosclerosis

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

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.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

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 ☐NOT WHILE AT WORK ☐

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 Oct 1, 1961 to Oct 1, 1961 and last saw him alive on 10:20 P.M.

Death occurred at 9:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

William J. Freter, D.O.

22b. ADDRESS

Bloomfield Mo

22c. DATE SIGNED

10-4-61

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

Oct. 3-61

23c. NAME OF CEMETERY OR CREMATORY

Bluff Cemetery

23d. LOCATION (City, town, or county)

Stoddard County, Mo.

24. FUNERAL DIRECTOR

ADDRESS

CHILES UND. CO., BLOOMFIELD, MO.

25. DATE RECD. BY LOCAL REG.

10-7-61

26. REGISTRAR'S SIGNATURE

Drew Kasten

(Licensed Embalmer's Statement on Reverse Side)

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 Lulu Cooper #3499, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Lulu C. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.