

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5428 **63-040172**
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

VS 300
Rev. 4/59

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2 3878
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94200
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in lb <u>60</u> years	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>2401 E Meyer Blvd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lilburn E. Snodgrass</u>			4. DATE OF DEATH Month Day Year <u>October 4, 1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1897</u>
9. AGE (last birthday) <u>66</u>		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) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Post Office</u>	11. BIRTHPLACE (City and state or country) <u>Polk County, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Ernest Snodgrass</u>	
13b. MOTHER'S MAIDEN NAME <u>Cora Chittenden</u>		14. NAME OF HUSBAND OR WIFE <u>Anna K. Snodgrass</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>8131 McGee</u>	
17. INFORMANT <u>L. E. Snodgrass Jr</u>		Address <u>Kansas City, Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic heart disease</u>			<u>1 year</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
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 _____ 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 <u>1/9/59</u> to <u>10/4/63</u> and last saw him alive on <u>10/4/63</u> Death occurred at <u>10/4/63 2:25 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>G. Leitch M.D.</u>		(Degree or title)	22b. ADDRESS <u>508 S 15 Blue Springs Ave</u>
22c. DATE <u>10/5/63</u>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-7-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>
23d. LOCATION (City, town, or county) <u>Kansas City, Missouri</u>		23e. STATE <u>Missouri</u>	
24. FUNERAL DIRECTOR <u>Floral Hills Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>10-7-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>
ADDRESS <u>Kansas City, Mo.</u>			

Mr. C. H. Foster
808 So. 15th
Albany, Georgia

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 *E. M. Joiner*

Licensed Embalmer No. 3453

P. O. Address K. E. Bon

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.