

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

25002

1. PLACE OF DEATH

County Houston Registration District No. 608.
 Township S. Franklin Primary Registration District No. 5807
 City Dominion, Mo. (No.) St. Ward)

File No.
 Registered No. 17

2. FULL NAME Ressy Scott Snare

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Elizabeth Snare
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 22 1906
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 80 6 22

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Pennsylvania
 (STATE OR COUNTRY) Huntington County

10. NAME OF FATHER John P. Snare

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Strasburg
 (STATE OR COUNTRY) Virginia

12. MAIDEN NAME OF MOTHER Nancy Kurbman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Pennsylvania
 (STATE OR COUNTRY) Huntington County

14. INFORMANT Elizabeth Snare
 (Address) Fairview, Mo.

15. FILED Aug 31 1927 J. P. Parness
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 18, 1927
 17. I HEREBY CERTIFY, That I attended deceased from Aug 18, 1927 to Aug 18, 1927 that I last saw him alive on Aug 18, 1927, and that death occurred, on the date stated above, at 2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chest Injuries Caused by Bull.

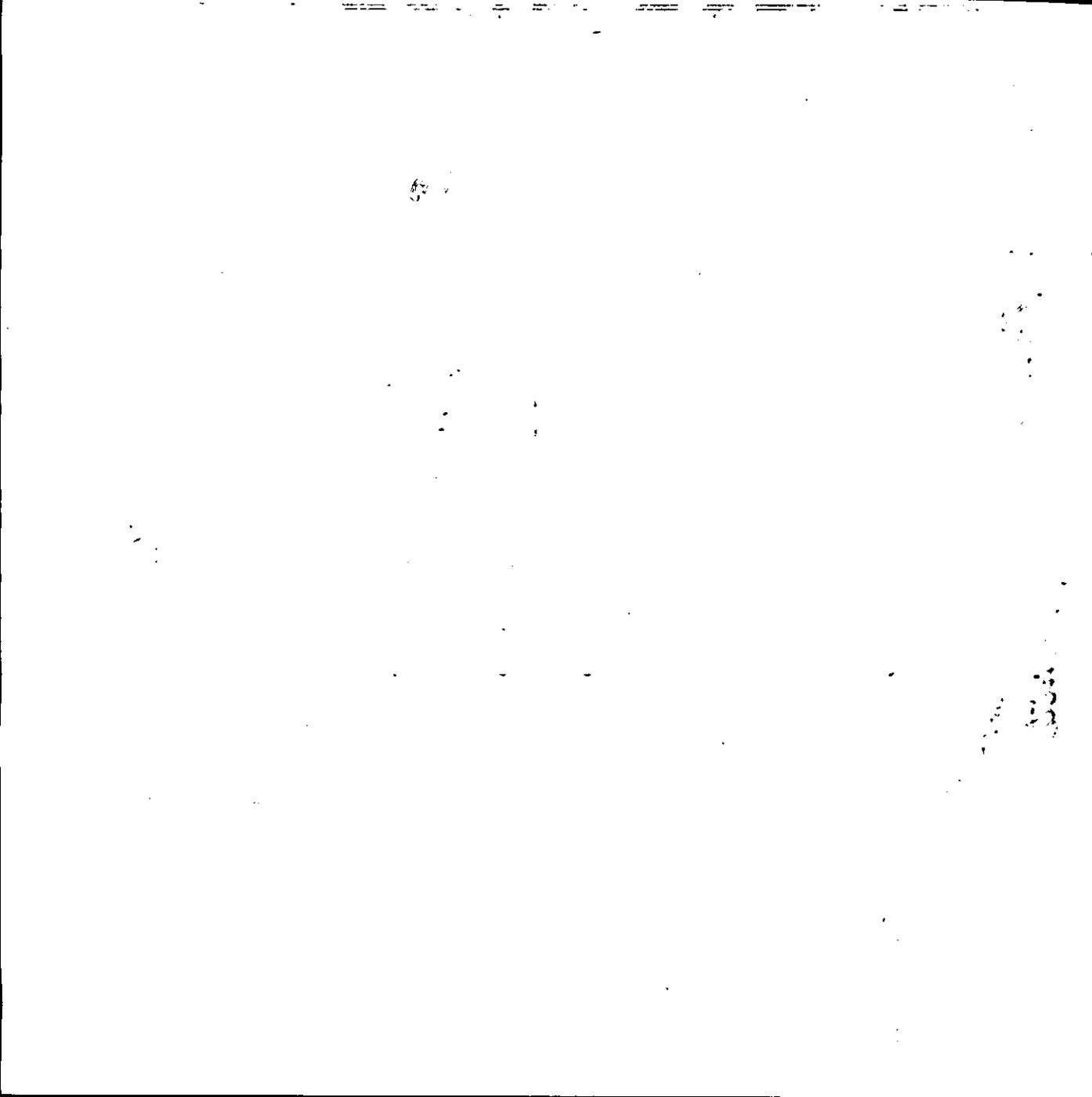
CONTRIBUTORY (SECONDARY) 189 (duration) yrs. mos. da. Three

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH?
 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS? St. J. Keller, M.D.
179, 1927 (Address) Fairview Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Rucky Comfort, Mo DATE OF BURIAL Aug 21 - 1927

20. UNDERTAKER J. H. White ADDRESS Fairview, Mo.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Newton Registration District No. 608 File No.
 Township E. Gravelle Primary Registration District No. 5-807 Registered No. 17
 City (No.) St. Ward)

2. FULL NAME

Reasy Scott Inare
 (a) Residence. No. St., Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Elizabeth Inare

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 26-1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

PARENTS

14. INFORMANT

(Address)

15. FILED Oct-11-27 L. N. Parnell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 18 19 27

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

5-25002