

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

W. J. Gaebe
REC'D APR 11 1939

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

12156
Do not use this space.

1. PLACE OF DEATH
(a) County St. Francois Registration District No. 779
(b) Township Republic Primary Registration District No. 66240
(c) City DeSloge Mo (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Berry Hanson Snyder
(a) Residence, No. DeSloge Mo St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Malissa Snyder

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 22, 1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>89</u>	<u>9</u>	<u>27</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

FATHER

13. NAME Washington Snyder

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Wm Snyder
RFD #2 Bond Lane Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE B. T. Cemetery DATE March 24, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Shelton and Co
Corner of Cedar Mo

20. FILED 4-10-39 W. F. Huebner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from 3-1-39 to 3-19-39
I last saw him alive on 3-18-39 Death is said to have occurred on the date stated above, at 4:35 A. M.
The principal cause of death and related causes of importance were as follows:
Pneumo-pneumonia Date of onset 3-16-39

Other contributory causes of importance: Influenza
Chy. proctocolitis
Ch. nephritis

Name of operation _____ Date of _____
What test confirmed diagnosis? Clement Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Harold C Gaebe, M. D.
DeSloge Mo (Address)

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, *A. J. Claywell*

....., or by

Registered Apprentice No., working under my personal supervision.

Signed *A. J. Claywell*

.....
Licensed Embalmer No. *3706*

P. O. Address *Bonnie Street N.*

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 this body is not embalmed, above space should be left blank.