No. 2
1-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 1 6 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25166

Registration District No. 317 Primary Registration District No. 4192 Registrar's No.

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Republic Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution No (Specify whether
In this community 5 Months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Greene

(c) City or town Republic Mo
(If outside city or town limits, write "RURAL")

(d) Street No. N Main
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 69 years.

3. (a) PRINT FULL NAME Cora Dell Snyder 536

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex F

5. Color or race W Caucasian

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb (Month) 1 (Day) 1871 (Year)

8. AGE: Years 69 Months 5 Days 29 If less than one day hr. min.

9. Birthplace Chicago Ill (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Harvey Cooper
13. Birthplace Ill (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Cooper
15. Birthplace Ill (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Floyd W Fx

(b) Address Republic Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Symmoore Mo

18. (a) Signature of funeral director [illegible] Funeral Home

(b) Address 429 W Walnut

19. (a) July 31 (Date received local registrar) (b) Mrs Bertha Nance (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30
year 1940 hour 9:20 minute a m M.

21. I hereby certify that I attended the deceased from Oct 17, 1936, to July 29, 1940
that I last saw her alive on July 29, 1940;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of the rectum	3½ yrs
Due to undetermined	
Due to	
Other conditions None (Include pregnancy within 3 months of death)	

Major findings:
Of operations None except biopsy for diagnosis
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: ✓

(a) Accident, suicide, or homicide (specify) ✓

(b) Date of occurrence ✓

(c) Where did injury occur? ✓ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 2 (Specify type of place)

While at work? ✓ (e) Means of injury 1

23. Signature Don H. Selsby (M. D. or other) M. D.

Address July 30 1940 Date signed 7/30/40 Springfield Mo.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Greene County Health Office,
County File Number 40-8-52
Date Filed 8-12-40

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 .....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Floyd W. Fox

Licensed Embalmer No. 2910

P. O. Address Republic Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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