FILED OCT 10 1940

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

31414
Do not use this space.

1. PLACE OF DEATH
(a) County BUCHANAN
(b) Township
(c) City or ST. JOSEPH
Registration District No. 1
Primary Registration District No. 1013
Registered No. 967
(d) Street No. ST. JOSEPH HOSPITAL St.
(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 3 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Winslow P. Snyder
(a) Residence, No. Rev Rivers Mission 621 So 8th St. St. Joseph Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): June 27, 1867
7. AGE: Years 73 | Months 2 | Days 6 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Carpenter
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): Frazer, Mo.

FATHER
13. NAME: unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown

MOTHER
15. MAIDEN NAME: unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown

17. INFORMANT (ADDRESS): Raymond W. Snyder, 2822 Sacremento
18. BURIAL, CREMATION, OR REMOVAL PLACE Frazer Mo DATE Sept 5 1940
19. FUNERAL DIRECTOR (NAME) Tracy Barry Funeral Home (ADDRESS) 218 South 10th St
20. FILED Sept 5, 1940 H. J. Kestebaum Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/3 1940

22. I HEREBY CERTIFY, That I attended deceased from 8-8, 1940 to 9-3, 1940
I last saw him alive on 9/3, 1940 Death is said to have occurred on the date stated above, at 6:30 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Embolism	9/3/40

Other contributory causes of importance:
Supra pubic Prostatectomy

Name of operation See above Date of
What test confirmed diagnosis? Clinical 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
Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Chas. A. Greenberg, M. D.
(Address) Physicians & Surgeons Bldg. St Joseph Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

WRITE WITH STABBING INK—THIS IS A PERMANENT RECORD

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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 Victor Barry, Registered Apprentice No. 252 working under my personal supervision.

Signed John E. Myers

Licensed Embalmer No. 3220

P. O. Address St. Joseph, Mo

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

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

No. 2B
-2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31414

Registration District No. 85 — Primary Registration District No. 1001 — Registrar's No. 967

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Buchanan

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

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

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

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

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

3. (a) PRINT FULL NAME Winslow P. Snyder

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 73 Months 2 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Nov. 19, 1940 (Date received local registrar) (b) H. Mistlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 3 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 1940, to 9/3/ 1940; that I last saw him alive on 9/3/ 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism

Due to 127

Due to Hypertrophied Prostate Retention of Urine

Other conditions Supra Pubic Prostatectomy (Include pregnancy within 3 months of death)

Major findings: Of operations Date of operation 8/21/40

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Chas Glen Berg (M. D. or other)

Address P & S Bldg Date signed 11/18/40