

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38994**

Registration District No. **426**

Primary Registration District No. **5581**

Registrar's No. **17**

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Magnolia Johnson
(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)
In this community _____ years, months or days 2

3. (a) PRINT FULL NAME Jimmie Gayle Snare
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 15 - 1940
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>0</u>	<u>0</u>	<u>0</u>	<u>5</u> hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____
MOTHER FATHER {
12. Name Hubert Snare _____
13. Birthplace Centerville Johnson _____
(City, town, or county) (State or foreign country)
14. Maiden name Ester Debit
15. Birthplace Warrensburg Johnson _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hubert Snare
(b) Address Magnolia Missouri

17. (a) Piagah Johnson (b) Date thereof 11-16-40
(Burial or cremation, as indicated) (Month) (Day) (Year)
(c) Place: burial or cremation Piagah

18. (a) Signature of funeral director W.P. Hilt
(b) Address Warrensburg Mo

19. (a) 11-16-40 (b) O. L. Dease
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
(c) City or town Magnolia
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11-15-40 Day _____
year 6 PM hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from 11-15-40
_____ 19____, to 11-15-40 19____;
that I last saw h. l. alive on 11-15-40 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital cardiac defect
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature O. F. M. [Signature] (M. D. or other) _____
Address Warrensburg Mo Date signed 11-16-40

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

FORM 1 X 1931
REV. 5-17-39

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.

RECEIVED
District Health Officer No. 8
District File Number 12-4-40
Date Filed

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.....

Licensed Embalmer No.....

P. O. Address.....

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.