

No. 2
-1-4-41
5-17-39
K 26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FEB MAR 14 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6072
814

State File No. _____

Registration District No. 399

Primary Registration District No. 100

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: K.C. General Hospital No. 10
(d) Length of stay: In hospital or institution 2 days
In this community 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(d) Street No. 2919 Wyandotte
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Dr. Arthur L. Snead

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 Divorced
6. (b) Name of husband or wife Betsy Snead 6. (c) Age of husband or wife if alive 38 years
7. Birth date of deceased Mo. 1. 1902

8. AGE: 68 Years Months Days If less than one day hr. min.

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

10. Usual occupation Doctor

11. Industry or business None

MOTHER FATHER
12. Name Arthur L. Snead
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name None
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Betsy Snead

(b) Address 2919 Wyandotte

17. (a) Burial (b) Date thereof 2-27-41

(c) Place: burial or cremation Forest Hill

18. (a) Signature of funeral director Rob. Walker

(b) Address 7406 Franklin

19. (a) 2/27/41 (b) Dr. M. M. Crowe

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 25th
year 1941 hour 12 minute 55 P. M.

21. I hereby certify that I attended the deceased from 2-23-41 to 2-25-41
that I last saw him alive on 2-25-41
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac decompensation

Due to ASD
Due to ASD

Other conditions ASD
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy None above

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? _____

While at work? _____ (Specify type of place) Means of injury None

23. Signature Dr. M. M. Crowe (M. D. or other) _____
Address Med. Dir. K. C. Gen. Hospital K. C. Mo. Date signed _____

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

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.....
Harlyn Lee....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Harlyn Lee
Licensed Embalmer No. *2810*
P. O. Address *H. C. M.*

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; fact should be so stated above.