

FILED APR 15 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **9538**  
Registrar's No. **947**

Registration District No. 397

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: K.C. General Hospital No. 10  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day (Specify whether  
In this community no record years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. No. 5710 Anderson  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MAGGIE SNYDER

3. (b) If veteran, name war — 3. (c) Social Security No. none

4. Sex ♀ 5. Color or race wh 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: Dec. - 2 - 1873  
(Month) (Day) (Year)

8. AGE: Years 67 Months 3 Days 3 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name no Record  
13. Birthplace — (City, town, or county) (State or foreign country)  
14. Maiden name —  
15. Birthplace — (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. A. E. Johnson  
(b) Address Creston, Iowa

17. (a) removal (b) Date thereof 3-7-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Creston, Iowa

18. (a) Signature of funeral director Bentley Westberry  
(b) Address 5811 Transit

19. (a) Mar 7, 1941 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5th  
year 1941 hour 9 minute 05 P. M.

21. I hereby certify that I attended the deceased from 3-5-41 19. to 3-5-41 19.  
that I last saw her alive on 3-5-41 19.  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage into lateral and third ventricle

Due to —  
Due to —

Other conditions: Pulmonary congestion  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
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 0  
23. Signature Dr. R. Howard (M. D. or other) \_\_\_\_\_  
Address Med. Dir. K.C. Gen. Hospital, K. Mo.

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

18  
24

---

---

**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, fact should be so stated above.**