

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 5 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15801

State File No.

Registration District No. 32

Primary Registration District No. 22

Registrar's No.

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Union Mills
(If outside city or town limits, write "RURAL" and name of township):
(c) Name of hospital or institution: 1
(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)

3. (a) PRINT FULL NAME Kizzie Snow

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Albert Snow 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased Oct 28 1889
(Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days 27 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Joseph Williams

13. Birthplace Cent. Knowl (City, town, or county) (State or foreign country)

14. Maiden name Mary Ann Davis

15. Birthplace Cent. Knowl (City, town, or county) (State or foreign country)

16. (a) Informant Albert Snow

(b) Address Grave Springs, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/26/43 (Month) (Day) (Year)

(c) Place: burial or cremation M. B. Bude

18. (a) Signature of funeral director _____

(b) Address None

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25 year 1943 hour 10 minute 2 M.

21. I hereby certify that I attended the deceased from April 23 1943 to April 25 1943; that I last saw her alive on April 24 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure Duration _____

Due to Coronary occlusion

Due to Hypertensive heart disease

Other conditions Emboli

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

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) (e) Means of injury _____

23. Signature Arthur A. Franco (M. D. or other) D.O.

Address Lelargon, Mo. Date signed 4/27/43

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.....

No Embalming....., Registered Apprentice No.....
working under my personal supervision.

Signed *Dorsey M. Howe*.....

Licensed Embalmer No. *4222*

P. O. Address *Lebanon Mo.*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 380

Primary Registration District No. 6288

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Union Gap
(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

3. (a) PRINT FULL NAME Kippe Snow

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Albert 6. (c) Age of husband or wife if alive 6-8 years

7. Birth date of deceased Oct 28 1943
(Month) (Day) (Year)

8. AGE: Years 53 Months 5 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

MOTHER FATHER

12. Name _____

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 _____

(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) 5-5-1943 (Date received local registrar) (b) Gabe M. Vestal (Registrar's signature)

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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 Year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

105 1000

1001

1002 1003

1004

15801

1005