

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 2185

FILED JUN 7 1943
Registration District No. 749

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:
5932 Lister
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution _____ (Specify whether)
In this community 30 yrs
years, months or days)

3. (a) PRINT FULL NAME

Harriet A. Snoddy

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Femal/ 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Thomas E. Snoddy 6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased June 1 1867
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>11</u>	<u>7</u>	hr. _____ min.

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

10. Usual occupation House wife

MOTHER FATHER

11. Industry or business _____
12. Name Cyler Green 7
13. Birthplace no record (City, town, or county) (State or foreign country)
14. Maiden name no record
15. Birthplace no record (City, town, or county) (State or foreign country)

16. (a) Informant Thomas E. Snoddy
(b) Address 5932 Lister

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11 1943
(Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn Com.

18. (a) Signature of funeral director Mrs C.L. Forster
(b) Address 918 Brooklyn

19. (a) 5-11-43 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 5932 Lister
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 8
year 43 hour 5:55 minute P M.

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

Immediate cause of death Arteriosclerotic heart disease
Due to _____
Due to _____

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

Major findings: Of operations _____
Of autopsy Infection & injury

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) (c) Means of injury _____
23. Signature [Signature] M. D. or other _____
Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

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

Signed *Theron A. Redman*.....

Licensed Embalmer No..... *2737*.....

P. O. Address..... *R. P. 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.