

Registration District No. **149**

Primary Registration District No. **1002**

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

**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: 1301 Wabash  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 2.5 yrs (Specify whether  
years, months or days)

**3. (a) PRINT FULL NAME** Mary F. Snorgrass  
**3. (b) If veteran,** name war No **3. (c) Social Security** No. 710

**4. Sex** Female **5. Color or** White **6. (a) Single, widowed, married,** widow  
1 2 divorced  
**6. (b) Name of husband or wife** M Snorgrass **6. (c) Age of husband or wife if** alive years  
**7. Birth date of deceased** March 22 1853  
(Month) (Day) (Year)

**8. AGE:** Years 94 Months 5 Days 2 If less than one day  
hr. min.

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

**10. Usual occupation** at home

**11. Industry or business**

**MOTHER FATHER**  
**12. Name** No Record  
**13. Birthplace** No Record 9 (City, town, or county) (State or foreign country)  
**14. Maiden name** No Record  
**15. Birthplace** No Record 9 (City, town, or county) (State or foreign country)

**16. (a) Informant** Ettie D Young  
**(b) Address** 1301 Wabash  
**17. (a) Removal** Removal **(b) Date thereof** Aug 27-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** Rural

**18. (a) Signature of funeral director** W. C. Fort  
**(b) Address** 918 Broadway  
**19. (a) Date received local registrar** Aug 26 1943 **(b) Registrar's signature** J. E. Brown

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Jackson **48**  
(c) City or town Kansas City **3**  
(If outside city or town limits, write "RURAL") **8**  
(d) Street No. 1301 Wabash  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Aug day 24  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_  
**21. I hereby certify that I attended the deceased from** Jan 1940 to Aug 24 1943  
**that I last saw her alive on** Aug 24 1943  
**and that death occurred on the date and hour stated above.**

**Immediate cause of death** Heart irregularities **Duration** 3 or 4 yrs.  
Chronic myocarditis

**Due to** Floral Infection  
**Due to** \_\_\_\_\_

**Other conditions** Chronic obstructive neph  
(Include pregnancy within 3 months of death)

**Major findings:** Starry W. Dwyer **PHYSICIAN**  
**Of operations** 1401 P. Dwyer  
**Of autopsy** no

**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?

**23. Signature** Starry W. Dwyer (Specify type of place) (M. D. or other)  
**Address** 1401 P. Dwyer **Date signed** 8-24-43  
**(e) Means of injury** \_\_\_\_\_

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 *W. E. Manning*.....

Licensed Embalmer No. *25224*.....

P. O. Address *K. O. 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.