

FILED SEP 14 1953

State File No. \_\_\_\_\_  
Registrar's No. 81

Registration District No. 200

Primary Registration District No. 3041

1. PLACE OF DEATH:

(a) County MACON  
(b) City or town MACON  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Samaritan Hospital  
(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 1/2 Day

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby 102  
(c) City or town CLARENCE  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Carol Sue Snodgrass

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

4. Sex fe 5. Color or race 1  
6. (a) Single, widowed, married, divorced 0  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 19 1943  
(Month) (Day) (Year)

8. AGE: Years  Months  Days  If less than one day 18 hr.  min.

9. Birthplace MACON Mo 11  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name WALTER RAY Snodgrass  
13. Birthplace Mo 0  
(City, town, or county) (State or foreign country)  
14. Maiden name MARTHA HAMRICK  
15. Birthplace CLARENCE Mo 11  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. H. L. Hamrick  
(b) Address Clarence Mo

17. (a) Burial (b) Date thereof 8-27-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maplewood (Clarence)

18. (a) Signature of funeral director C. E. [Signature]  
(b) Address Clarence Mo

19. (a) 9/14/53 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19  
year 1943 hour \_\_\_\_\_ minute 7 P. M.

21. I hereby certify that I attended the deceased from Aug 19 1943  
to Aug 19 1943  
that I last saw he alive on Aug 19 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Conjugal atelectosis  
Duration 1 day 13 hrs

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 16 1/2

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)  
(c) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other)  
Address Clarence Mo Aug 19 1943

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

RECEIVED

District Health Officer No. 10

State File No. <sup>9-43-1518</sup>  
~~SEP 10 1943~~

Date Filed ~~.....~~

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..... *Louis C. Hopper*

Licensed Embalmer No. *1261*

P. O. Address..... *Clarney, 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.

28735-  
State File No. *Sept.*

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County *Macon*  
(b) City or town *Macon*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: *Sumner Hospital*  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution *1/2 da.* (Specify whether years, months or days)

3. (a) PRINT FULL NAME *Carol S. Snodgrass*

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 *S*

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased *Aug. 19 1943*  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ Unless than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) *11/17/43* (b) *Nora B. Hunter*  
(Date received local registrar) (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 *Aug* year *1943* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I first saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

28735