

FILED AUG 10 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23981
Registrar's No. 178

Registration District No. _____

Primary Registration District No. 3000

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1704 S. Porter
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days) Most of life (Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Kirksville
(If outside city or town limits, write "RURAL")
(d) Street No. 1704 S. Porter
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Talcut R. Snow
3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Nellie Snow 6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Sept. 26 1870
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 8
year 1944 hour 7:00 minute A: M.
21. I hereby certify that I attended the deceased from MAR 10
1944 to July 1, 1944
that I last saw him 100 alive on July 1, 1944
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
73 9 12 hr. min.

Immediate cause of death apoplexy
Due to _____
Due to _____

9. Birthplace Unknown Iowa
(City, town, or county) (State or foreign country)
10. Usual occupation Day Laborer

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

11. Industry or business _____
12. Name Elijah Snow
13. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Jane Vice
15. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Nellie Snow
(b) Address Kirksville, Mo
17. (a) Burial (b) Date thereof 7/9/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sloans Point

While at work _____ (Specify type of place) _____
Means of injury _____
23. Signature O. P. Marlowe (M. D. or other) _____
Address Kirksville Date signed _____

18. (a) Signature of funeral director D. E. Riley
(b) Address Kirksville, Missouri
19. (a) 7-19-44 (b) Mrs. J. Wagon
(Date received local registrar) (Registrar's signature)

23. Signature O. P. Marlowe (M. D. or other) _____
Address Kirksville Date signed _____

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

Duration

83a

1049

017807

[Handwritten signature]

RECEIVED

District Health Officer No. 10

District File Number 8-44-1384

Date Filed AUG 9 1944

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 *[Signature]*

Licensed Embalmer No. 4181

P. O. Address *[Handwritten 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.