

FILED NOV 12 1946

Registration District No. 149

Primary Registration District No. 1001

Registrar's No. 4587

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: ST MARY'S HOSPITAL 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 WEEK  
(Specify whether  
in this community 50 YEARS  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON  
(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5905 CENTRAL  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME: DR. JOSEPH SCOTT SNIDER

3. (b) If veteran, name war WORLD WAR I 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 MRS. KATHERINE SNIDER 6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased AUGUST 25 1876  
(Month) (Day) (Year)

8. AGE: Years 70 Months 2 Days 4 If less than one day hr. min.

9. Birthplace Marion County Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation PHYSICIAN - M.D.

11. Industry or business OFFICES RIALTO BLDG.

12. Name Andrew J. SNIDER

13. Birthplace Marion County Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name Mary E. Fuke

15. Birthplace Marion County Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. G. S. Suedea

(b) Address 5905 Central

17. (a) BURIAL (b) Date thereof OCT 31 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director W. H. Howerman, Son

(b) Address 1401 BRUSH CREEK BLYD.

19. (a) 10-31-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 29<sup>TH</sup>  
year 1946 hour 11 minute 00 A. M.

21. I hereby certify that I attended the deceased from March  
1946 to Oct. 29 1946;  
that I last saw him alive on Oct. 29 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Failure Duration four hrs.

Due to Inanition Four weeks

Due to Carcinoma of Rt. Lung ?  
(Known 3 mo.)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 47 N  
Of operations Bronchoscopy  
(Biopsy proved Ca)  
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 Harold M. Roberts (M. D. or other) M. D.  
Address 1103 Grand, K.C., Mo Date signed 10-30-46

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

MOTHER FATHER

1600 Professional Bldg.  
2-5

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**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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC 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.**