

No. 2
9-43
1739
EX37823

State File No. _____

NOV 15 1947
Registration District No. 385

Primary Registration District No. 3039

Registrar's No. 143

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

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Marceline
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
410 E. Gracia St (Home)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Chariton

(c) City or town Marceline Rural
(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 Margaret Miranda Snider

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 11
year 1947 hour 4 minute 15 P.

21. I hereby certify that I attended the deceased from October 8, 1947, to October 11, 1947;
that I last saw her alive on October 11, 1947;
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife William Snider

6. (c) Age of husband or wife if alive 86 years 1866

7. Birth date of deceased: August 5
(Month) (Day) (Year)

Immediate cause of death ventricular fibrillation

Due to	Duration
<u>congestive heart failure</u>	<u>12 da.</u>
<u>coronary occlusion</u>	<u>12 da.</u>

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

8. AGE: Years 81 Months 2 Days 6 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

Major findings: g4ff

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

11. Industry or business _____

12. Name Archibald Spencer

13. Birthplace Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Susand Kawp

15. Birthplace Penn
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Nellie Underwood

(b) Address Marceline Mo

17. (a) Burial (b) Date thereof Oct. 13-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Olive

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? _____

18. (a) Signature of funeral director James M Laughlin

(b) Address Marceline Mo

19. (a) _____ (b) LE. Shelton
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury U

23. Signature P.A. Ottman (M. D. or other) M.D.

Address Marceline, Mo. Date signed 10/13/47

REC-117
FEB 9, 1946

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

Libburn Keith Tillston....., Registered Apprentice No. 438
working under my personal supervision.

Signed Blanche McLaughlin
Licensed Embalmer No. 1909
P. O. Address Marceline, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 702
Registrar's No. 143

Registration District No. 385 Primary Registration District No. 3039

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

1. PLACE OF DEATH: Leun
(a) County Leun
(b) City or town Mauclell
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Margaret M. Snider
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 m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____
7. Birth date of deceased: Aug 5 1881
(Month) (Day) (Year)

8. AGE: Years 81 Months 2 Days 28 (If less than one day) _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (Date received local registrar) (b) ER Shelton (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 11 year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

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

Duration _____
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 _____

SUPPLEMENTARY

S-34990