

10-47
17-39
3906

Primary Registration District No. 4078

1. PLACE OF DEATH:
(a) County Cape Girardeau Mo
(b) City or town Delta Mo
(c) Name of hospital or institution: Family Home 1
(d) Length of stay: In hospital or institution none
In this community all life (Specify whether years, months or days)

3. (a) PRINT FULL NAME George F. Snider
3. (b) If veteran, name war.
3. (c) Social Security No.

4. Sex Male 5. Color or race w
6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Ellen
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March 1 - 1882 (Month) (Day) (Year)

8. AGE: Years 66 Months 7 Days 13 If less than one day hr. min.

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

10. Usual occupation Carpenter

11. Industry or business

12. Name Wash Snider

13. Birthplace Cape Gir. Co. Mo (City, town, or county) (State or foreign country)

14. Maiden name Mary V. Snider

15. Birthplace Cape Gir. Co. Mo (City, town, or county) (State or foreign country)

16. (a) Informant Herbert Snider
(b) Address Delta Mo

17. (a) Burial (b) Date thereof: 11-16-48 (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director J. H. Havelle
(b) Address Cape Girardeau Mo

19. (a) 11-16-48 (Date received by registrar) (b) R. F. Snider (Registrar's signature) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cape Mo
(c) City or town Delta Mo (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 November day 14 year 1948 hour 7 P. minute
21. I hereby certify that I attended the deceased from March 1947 that I last saw him alive on Nov 14 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to high arterial tension

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 830 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 Wm D. Swant (M. D. or other) M D Address Allamore Mo Date signed Nov 16 1948

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 1248-14

Date Filed 12-2-48

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. H. Easter

Licensed Embalmer No. 3568

P. O. Address Cape Girardeau

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.