

FILED AUG 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25991

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>4001</u>		Registrar's No. <u>249</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Novinger</u>		c. LENGTH OF STAY (In this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Novinger</u>		d. STREET ADDRESS (If rural, give location) <u>Novinger, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Roy</u> b. (Middle) <u>Cecil</u> c. (Last) <u>Snyder</u>			4. DATE OF DEATH (Month) <u>Aug.</u> (Day) <u>17</u> (Year) <u>1949</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 1, 1890</u>	9. AGE (In years last birthday) <u>58</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburg, Kansas.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>W. D. Snyder</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Worley</u>		14. NAME OF HUSBAND OR WIFE <u>Velma Agnes Schillie</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>101</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Velma Snyder, Novinger, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Throat</u>  - ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Alcoholism</u> DUE TO (c) <u>Unstable Nervous</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Sporadic Cancers</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
19a. DATE OF OPERATION <u>Mar 4, 1949</u>		19b. MAJOR FINDINGS OF OPERATION <u>Glandular infection in neck</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Novinger Adair Mo.</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Novinger Adair Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/17</u> , 19 <u>49</u> , to <u>8/17</u> , 19 <u>49</u> that I last saw the deceased alive on <u>8/17</u> , 19 <u>49</u> , and that death occurred at <u>12:30 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>RS Gashwiler M.D.</u>				23b. ADDRESS <u>Novinger Mo.</u>		23c. DATE SIGNED <u>8/17/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8/19/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Novinger</u>		24d. LOCATION (City, town, or county) (State) <u>Novinger, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-20-49</u>		REGISTRAR'S SIGNATURE <u>Wato Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Worley</u>		ADDRESS <u>Kirkville, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 29 1949  
District Health Officer No. 10  
District File Number 8-49-148  
Date Filed AUG 29 1949

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*Ray H. Messer*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4432

P. O. Address Kirksville, 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.