

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 14 1950

State File No. **301**

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 142

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY OR TOWN <u>St. Joseph</u>		c. CITY OR TOWN <u>Lexington</u>	
c. LENGTH OF STAY (In this place) <u>242 29 days</u>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No 2</u>			

3. NAME OF DECEASED
a. (First) Newton b. (Middle) Emerson c. (Last) Snider

4. DATE OF DEATH (Month) (Day) (Year) Feb 6 - 1950

5. SEX male 6. COLOR OR RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 1 8. DATE OF BIRTH July 7 - 1863 9. AGE (In years last birthday) 86 - Months 6 Days 29 Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Farming 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Daniel Snider 13b. MOTHER'S MAIDEN NAME Betsy Galladay 14. NAME OF HUSBAND OR WIFE Mrs Estie Delberry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT'S SIGNATURE OR NAME State Hospital Records, St. Joseph Mo. ADDRESS Resident No

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio-sclerosis-hypertension
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH unknown

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Jan 1, 1950, to Feb 6, 1950, that I last saw the deceased alive on Feb 6, 1950, and that death occurred at 12:05 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Forrest Thomas M.D. U 23b. ADDRESS St. Joseph Mo. 90 State Hospital No 2 23c. DATE SIGNED Feb 12 - 1950

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 2-6-50 24c. NAME OF CEMETERY OR CREMATORY Higginville 24d. LOCATION (City, town, or county) (State) Higginville MO.

DATE REC'D BY LOCAL REG Feb. 9, 1950 REGISTRAR'S SIGNATURE E. B. Jenkins 25. FUNERAL DIRECTOR'S SIGNATURE Forrest Thomas ADDRESS Higginville

(Licensed Embalmer's Statement on Reverse Side)

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

117
2

443K

DEC 17 1954

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 _____

Student Embalmer No. 354

working under my personal supervision.

Signed Forrest R. Hoelzer
Student Embalmer

Signed Forrest R. Hoelzer

Licensed Embalmer No. 4358

P. O. Address Highway 100
Trinidad

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.