

FILED JAN 31 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3660**

BIRTH NO. _____ REG. DIST. NO. **360** PRIMARY REG. DIST. NO. **6225** Registrar's No. **8**

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

1. PLACE OF DEATH a. COUNTY Nevada b. CITY OR TOWN Las Vegas c. LENGTH OF STAY (In this place) 6y 4mo 20d d. FULL NAME OF HOSPITAL OR INSTITUTION State Hosp 3		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Dickson c. CITY OR TOWN Kansas City 3848 d. STREET ADDRESS 830 West 58th Terrace	
3. NAME OF DECEASED a. (First) AMNETT b. (Middle) - MCGEE c. (Last) - SNYDER		4. DATE OF DEATH (Month) (Day) (Year) Jan 20, 1950	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 24, 1898
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Kansas City Mo
13a. FATHER'S NAME Allen B. H. McGee		13b. MOTHER'S MAIDEN NAME Novell Scheffey	14. NAME OF HUSBAND OR WIFE William D. Snyder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Records State Hosp 3 Nevada Mo.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dementia Precox ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
19a. DATE OF OPERATION Jan 16, 1950		19b. MAJOR FINDINGS OF OPERATION Prefrontal Lobotomy	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 13 years 3007 2 days	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	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) _____	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 Aug 31, 1943, to Jan 20, 1950, that I last saw the deceased alive on Jan 20, 1950, and that death occurred at 11:30 A.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Paul L. Barone M.D.		23b. ADDRESS State Hosp 3 Nevada Mo.	
23c. DATE SIGNED Jan 20/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	24b. DATE Jan 20, 50	24c. NAME OF CEMETERY OR CREMATORY unknown	24d. LOCATION (City, town, or county) (State) Kansas City Mo
DATE REC'D BY LOCAL REG. Jan 20, 1950	REGISTRAR'S SIGNATURE Nathyn H. Yancy	33	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McClure R. C. Mo

copy
near 7/10/50

RECEIVED

District Health Officer No. 71

District File Number 1249-202

Date Filed 1-20-50

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.

working under my personal supervision.

Student
Student Embalmer

Signed E. M. Plank

Licensed Embalmer No. 1848

P. O. Address. Y. C. 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.