

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **27557**

FILED AUG 12 1953

BIRTH NO.		REG. DIST. NO. 374	PRIMARY REG. DIST. NO. 4647	Registrar's No. 253
1. PLACE OF DEATH a. COUNTY Worth		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Worth		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Grant City		c. LENGTH OF STAY (in this place) 2 yrs		
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Grant City		
3. NAME OF DECEASED (Type or Print) a. (First) Bessie b. (Middle) Louise c. (Last) Snow		4. DATE OF DEATH (Month) (Day) (Year) August 2, 1953		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 9, 1890	9. AGE (In years last birthday) 63 IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and State or Foreign Country) Story County, Iowa	12. CITIZEN OF WHAT COUNTRY? U. S.
13a. FATHER'S NAME William Johnson		13b. MOTHER'S MAIDEN NAME Louise Emmerson	14. NAME OF HUSBAND OR WIFE John C. Snow	
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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS John C. Snow Grant City, Missouri	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis 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 1 hr
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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)	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 July 31, 1953 , to 2 Aug , 1953, that I last saw the deceased alive on 2 Aug , 1953, and that death occurred at 3:30 pm. , from the causes and on the date stated above.				
23a. SIGNATURE Frank B. Matson MD (Degree or title)		23b. ADDRESS Grant City, Mo.		23c. DATE SIGNED 8-4-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-4-1953	24c. NAME OF CEMETERY OR CREMATORY Navada Cemetery	24d. LOCATION (City, town, or county) (State) Navada, Iowa	
DATE REC'D BY LOCAL REG Aug. 8 - 1953	REGISTRAR'S SIGNATURE John E. Hoover	345	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bill A. Duffee Grant City, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

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 Bill A. Dunfee

Licensed Embalmer No. 49008

P. O. Address Grant City, 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.