

FILED FEB 16 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7026

BIRTH NO. _____		REG. DIST. NO. <u>349</u>		PRIMARY REG. DIST. NO. <u>4514</u>		Registrar's No. <u>7</u>	
1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Green City</u>		c. LENGTH OF STAY (in this place) <u>10 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Green City</u>		<u>1050</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Home in Green City</u>				d. STREET ADDRESS (If rural, give location) <u>No street address</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u>		b. (Middle) <u>Harvey</u>		c. (Last) <u>Snow</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 7, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 14, 1887</u>		9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Snow</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Hibbitts</u>		14. NAME OF HUSBAND OR WIFE <u>Marthe Jane Snow (deceased)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Walter Morris, Green City, 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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u> ANTECEDENT CAUSES <u>Chronic Nephritis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <u>2 weeks</u> <u>2 years</u>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____						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) <u>592X</u>			
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 <u>May 15, 1948</u> , to <u>Feb. 6, 1955</u> , that I last saw the deceased alive on <u>Feb 7, 1955</u> , and that death occurred at <u>11:30 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>R. D. Smith</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>Green City, Mo.</u>		23c. DATE SIGNED <u>2/8/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb. 10, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Green Castle Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Green Castle, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>Feb. 11, 1955</u>	REGISTRAR'S SIGNATURE <u>R. D. Cooper, deputy</u>		504-0		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sharon E. Kuttson, Green City, Mo.</u>		

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 _____

Karl R. Fent

Licensed Embalmer No. *4689*

P. O. Address *Green 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.