t. Health,
, & Welfare
S. Public
th Service

S. 300
v. 1-57

FILED APR 29 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 12841

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 395

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Hospital — Length of stay in Ib 20 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Greene
c. CITY OR TOWN Springfield 094 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 528 S. Lexington — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First WILLIAM Middle P. Last SNYDER
4. DATE OF DEATH Month April Day 25 Year 1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8. DATE OF BIRTH 28 Jan. 1892
9. AGE (In years last birthday) 65 — 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) Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY Lime Company
11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Franklin Snyder
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Divorced
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer lower lip with — INTERVAL BETWEEN ONSET AND DEATH 3 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) extensive cervical lymph
DUE TO (c) node metastases
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 140X
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]
20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 5/26/56, to 4/25/57 and last saw him alive on 4/25/57
Death occurred at 6:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Chas E Lockhart MD (Degree or title)
22b. ADDRESS 609 Cherry Springfield, Missouri
22c. DATE SIGNED 4/25/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 4-27-57
23c. NAME OF CEMETERY OR CREMATORY Hazelwood
23d. LOCATION (City, town, or county) Springfield, Missouri (State)

24. FUNERAL DIRECTOR J.W. Klingner & Co. ADDRESS Spgfd. Mo.
25. DATE RECD. BY LOCAL REG. 4-26-57
26. REGISTRAR'S SIGNATURE Edith Williamson

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 .....
Signature of Student Embalmer

Signed Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.