

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-035931  
STATE FILE NUMBER

FILED NOV 5 1958

Registration District No. 100 Primary Registration District No. 5384 Registrar's No. 95

1. PLACE OF DEATH a. COUNTY <b>Dent</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Dent</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>At Home, Linn</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Doss Mo. R R 3</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Residence</b>		Length of stay in lb <b>5 Yrs</b>	STREET ADDRESS (If outside, give location) <b>0 1 mile east of Doss</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>E.</b> Last <b>Snodgrass</b>			4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1 1887</b>	9. AGE (In years birthday) <b>71</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	11. BIRTHPLACE (City and state or country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>
13a. FATHER'S NAME <b>E.D. Snodgrass</b>		13b. MOTHER'S MAIDEN NAME <b>Gilley Talkington</b>		14. NAME OF HUSBAND OR WIFE <b>Anna E, Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>X</b>	17. INFORMANT Address <b>Mrs Bruce Halbrook Salem Mo.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>					INTERVAL BETWEEN INSGT. ADD DEATH <b>2 1/2 Wks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hydronephrosis</b>					
DUE TO (c) <b>Benign Prostatic Hypertrophy</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Marked cerebral arteriosclerosis - CVA 4 1/2 yrs ago 6/10X</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>July 1955</b> to <b>10/30/58</b> and last saw him alive on <b>10/29/58</b> Death occurred at <b>2.27 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>B. J. Bass, M.D.</b>			22b. ADDRESS <b>Salem, Mo.</b>		22c. DATE SIGNED <b>10/31/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov. 1, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Salem, Missouri</b>
24. FUNERAL DIRECTOR <b>Carl K. Spencer, Salem, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>10/31/58</b>		26. REGISTRAR'S SIGNATURE <b>M. M. [Signature]</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

0961 8 I AD

6956 4 7059

6956 4 7059

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 [Handwritten Signature]

Licensed Embalmer No. 2370 P. O. Address [Handwritten Address]

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.