

**JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS MAY 23 1960**

**=60-018874**  
 STATE FILE NUMBER

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 46

1. PLACE OF DEATH a. COUNTY <b>Dent</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dent</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <del>Doss</del> <b>Salem</b>		Length of stay in 1b <b>8 days</b>	c. CITY OR TOWN <b>Doss</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hart Clinic</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>rt 3</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Eward</b> Last <b>Snow</b>			4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-1-89</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>general</b>	11. BIRTHPLACE (City and state or country) <b>Licking Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>John Snow</b>		13b. MOTHER'S MAIDEN NAME <b>Clementine Owens</b>		14. NAME OF HUSBAND OR WIFE <b>Mary Snow</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 <b>Mary Snow rt 3 Salem Mo</b> Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b>			<b>seconds</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Aortic stenosis</b>		<b>3 yrs +</b>
	DUE TO (c) <b>Rheumatic Heart Disease</b>		<b>??</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Aneurysm</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 Month, Day, Year a.m. p.m.		

20d. INJURY OCCURRED WHILE AT WORK <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 <b>Salem, Mo</b>	COUNTY <b>Mo</b>	STATE
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21. I attended the deceased from **July 1957** to **5/16/60** and last saw <sup>her</sup>him alive on **5/10/60**  
 Death occurred at **7:05 A** m 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> (Degree or title)	22b. ADDRESS <b>Salem, Mo</b>	22c. DATE SIGNED <b>5/18/60</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>5-18-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Miner</b>
24. FUNERAL DIRECTOR <b>Spencer Funeral Home Inc</b> ADDRESS		23d. LOCATION (City, town, or county) <b>Dent Co Mo</b>

25. DATE RECD. BY LOCAL REG. <b>5/18/60</b>	26. REGISTRAR'S SIGNATURE <b>M. M. Hart, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Carl D. Payne

Licensed Embalmer No. 2321

P. O. Address Salmon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.