

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-029987

STATE FILE NUMBER

AMENDED FILED AUG 31 1961 Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 74

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Waspur</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Wet. Vernon</u>		Length of stay in 1b <u>9 day</u>		c. CITY OR TOWN <u>Webb City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>209 E. Broadway</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NATHAN</u> Middle <u>WILLIAM</u> Last <u>SNIDER</u>				4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 10 1905</u>	9. AGE (last birthday) <u>56</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCK DRIVER</u>		11. BIRTHPLACE (City and state or country) <u>OKLAHOMA</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM L. Snider</u>			13b. MOTHER'S MAIDEN NAME <u>IDA IDONIA ALLEN.</u>			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <u>no</u> or unknown) (If yes, give war or dates of service)				17. INFORMANT Address <u>Hospital Road</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAACINOMA of Lung</u>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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		COUNTY STATE	
21. I attended the deceased from <u>8-22-61</u> to <u>8-25-61</u> and last saw her alive on <u>1:15 AM.</u> Death occurred at <u>8-25-61 1:30A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (degree or title) <u>H. Vernon Langeluth, M.D.</u>			22b. ADDRESS <u>Mo. State Sanatorium</u>			22c. DATE SIGNED <u>8-25-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>8-25-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cartersville Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cartersville, Mo.</u>		
24. FUNERAL DIRECTOR <u>Johnston-Simpson, Webb City, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>8-26-61</u>		26. REGISTRAR'S SIGNATURE <u>H.D. Hassett.</u>		

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 Jack C. Simpson

Licensed Embalmer No. 4647

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

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