MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-033419
STATE FILE NUMBER

AMENDED

Registration District No. 164 Primary Registration District No. 5601 Registrar's No. 115

FILED OCT 9 1961

1. PLACE OF DEATH
a. COUNTY Johnson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Warrensburg — Length of stay in 1b: 3 Yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pleasantview Nurseing Home — Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Lafayette
c. CITY OR TOWN Odessa — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Hattie Middle Mae Last Snyder
4. DATE OF DEATH: Month Sept. Day 24, Year 1961
5. SEX: Fe
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 10-17-76
9. AGE (last birthday): 84 — 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): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Lafayette Co., Mo.
12. CITIZEN OF WHAT COUNTRY:
13a. FATHER'S NAME: Albert Schieber
13b. MOTHER'S MAIDEN NAME: Lucinda Crook
14. NAME OF HUSBAND OR WIFE: Deceased
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Hapie Heidbrink, Address Higginsville, Mo.

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) Adam-Stokes Syndrome (Cardiac Asystole)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Atherosclerotic Cornary Artery disease
DUE TO (c) Arteriosclerotic Cardiovascular Renal disease
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
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 9-25-61, to 9-25-61 and last saw her/him alive on —
Death occurred at 5:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Seth D. Jones, MD
22b. ADDRESS: Warrensburg, Mo
22c. DATE SIGNED: 9-

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Sept. 27, 1961
23c. NAME OF CEMETERY OR CREMATORY: Marvin Chapel Cem.
23d. LOCATION (City, town, or county) (State): Near Mayview, Mo.

24. FUNERAL DIRECTOR: Husman-Sparks, ADDRESS Odessa, Mo.
25. DATE RECD. BY LOCAL REG.: Sept. 30, 1961
26. REGISTRAR'S SIGNATURE: Lawrence Cutchfield

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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 [illegible]

Licensed Embalmer No. 7541

P. O. Address Odessa, 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.