

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

95 - 61-036522  
STATE FILE NUMBER

Registration District No. 120 Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

AMENDED

FILED NOV 7 1961

1. PLACE OF DEATH a. COUNTY <b>Gentry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gentry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Albany</b>	Length of stay in 1b <b>12 hours</b>	c. CITY OR TOWN <b>Athens Township</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Gentry County Memorial hospital</b>		d. STREET ADDRESS (If outside, give location) <b>Plainview Rest Home</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>WESLEY</b> Last <b>SNYDER</b>			4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1961</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>Sept. 10 '71</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months _____ Days _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farming (retired)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>agriculture</b>	11. BIRTHPLACE (City and state or country) <b>Taswell Co. Virginia</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>unknown</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Emily V. Crismond Snyder</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Dr. John R. Snyder</b>	Address <b>Valentine, Nebraska</b>
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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>Ca. Stomach</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>
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"/> No <input type="checkbox"/> Unknown	
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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 _____ a.m. _____ p.m. Month, Day, Year _____			

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>Albany</b>	COUNTY <b>Gentry</b>	STATE <b>MO</b>
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21. I attended the deceased from **June 1961** to **10-24-61** and last saw **him** alive on **10-24-61**  
Death occurred at **2:45 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Frank A. Rose, M.D.</b>	(Degree or title)	22b. ADDRESS <b>Albany, Mo</b>	22c. DATE SIGNED <b>10-25-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>Oct. 27, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grandview</b>	23d. LOCATION (City, town, or county) (State) <b>Albany, Missouri</b>
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24. FUNERAL DIRECTOR <b>Brooks-Cochell Funeral Home, Albany, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>11-1-1961</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. L. W. Bare</b>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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 me, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed Donald E. Cocheff

Licensed Embalmer No. 4868

P. O. Address Albany, 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.