

FILED OCT 25 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34107

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 224 PRIMARY REG. DIST. NO. 3046 Registrar's No. 61

1. PLACE OF DEATH a. COUNTY <u>Moniteau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Moniteau</u>	
b. CITY OR TOWN <u>California</u>		c. CITY OR TOWN <u>Clarksburg</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place)		e. STREET ADDRESS (If rural, give location) <u>0680</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Latham Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>THOMAS</u> b. (Middle) <u>HENDRIX</u> c. (Last) <u>SNODGRASS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 12 1955</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb-7-1883</u>	9. AGE (In years last birthday) <u>72</u>	10. MONTHS <u>8</u>	11. DAYS <u>5</u>	12. HOURS <u></u>	13. MIN. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Cooper Co. Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Wm F Snodgrass</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Friday</u>	14. NAME OF HUSBAND OR WIFE <u>Addie Davis Snodgrass</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>495-07-1125</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Addie Snodgrass</u>	ADDRESS <u>Clarksburg Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u>		<u>2 years</u>
	DUE TO (c) <u>4341</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July 19 55 to Oct 12 19 55, that I last saw the deceased alive on Oct 12 19 55, and that death occurred at 5 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Leon M. Gallagher MD</u>	23b. ADDRESS <u>California, Mo.</u>	23c. DATE SIGNED <u>10/17/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-14-1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Masonia Cemetery Mo</u>	24d. LOCATION (City, town, or county) (State) <u>Clarksburg Mo.</u>
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DATE REC'D BY LOCAL REG. <u>10/16/55</u>	REGISTRAR'S SIGNATURE <u>H R Payne</u>	506	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hugh E Williams</u>	ADDRESS <u>California Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Hugh E. Williams*

Licensed Embalmer No... 25...

P. O. Address *California*

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.