PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County Lewis

Township Salem

or

Village

or

City (NO. , St.: Ward)

Registration District No. 485

Primary Registration District No. 5648

File No. 17501

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Charles Leroy Spath

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Feb. (Month) 30 (Day), 1894 (Year)

AGE: 25 yrs. mos. 14 ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer. 11A

(b) General nature of industry, business, or establishment in which employed (or employer): General 10

BIRTHPLACE (City or town, State or foreign country): Lewis Co MO

PARENTS

NAME OF FATHER: Wm Spath

BIRTHPLACE OF FATHER (City or town, State or foreign country): MO

MAIDEN NAME OF MOTHER: Nettie Richardson

BIRTHPLACE OF MOTHER (City or town, State or foreign country): MO

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A C Harris

(ADDRESS) Steffinville MO

Filed May 15, 1919. J G Collins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 14 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from May 11, 1919, to May 14, 1919, that I last saw him alive on May 13, 1919, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia in both lungs

(Duration) yrs. mos. 8 ds.

Contributory (SECONDARY) Influenza

(Duration) yrs. mos. 8 ds.

(Signed) H F Rhodes M. D.

May 15, 1919 (Address) Philadelphia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Steffinville Cemetery

DATE OF BURIAL: May 15, 1919

UNDERTAKER: Thos. Ball

ADDRESS: Lewis MO

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) 1_____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), *191*____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL _____, 191____

UNDERTAKER | ADDRESS