

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

Do not use this space.

0223

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City St. Louis, Mo. (No. Sanitarium) St. _____ (Ward)

File No. _____
Registered No. **1460**

2. FULL NAME

John M. Spangler, Sr.
(a) Residence. No. 2702 Academy 13 Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. 4 mos. 0 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Anna Spangler

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 21, 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 7 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work conductor
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Irving
(STATE OR COUNTRY) Illinois

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Harrisburg
(STATE OR COUNTRY) Pennsylvania

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Raleigh
(STATE OR COUNTRY) North Carolina

14. INFORMANT R. H. Russell
(Address) City Sanitarium

15. FILED SEP 11 1927 Man 6 Starkloff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-9-1927

17. I HEREBY CERTIFY That I attended deceased from Oct 11, 1926 to 2-9-1927, 1927
that I last saw him live on 2-9-1927, 1927, and that death occurred, on the date stated above, at 6:00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchitis Pneumonia

CONTRIBUTORY (SECONDARY) 100%
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) R. H. Russell, M. D.

2-9-1927 (Address) City Sanitarium

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL No Crematory DATE OF BURIAL 2-12 1927

20. UNDERTAKER Peety Bros 3829 Lafayette ADDRESS

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

