

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

Do not use this space.

9650

1. PLACE OF DEATH

County.....
 Township.....
 City.....

Registration District No. **791**
 Primary Registration District No. **1003**

File No.
 Registered No. **2172**
 Ward.....

2. FULL NAME

Clara Smith Spinko

(a) Residence. No. **802 S. Tenth** St., **12** Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov-19-1889*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
37 3 14

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) *Springfield Mo.*
 (STATE OR COUNTRY)

10. NAME OF FATHER *John Neice*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Springfield Mo.*
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Mellie Neice*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Springfield Mo.*
 (STATE OR COUNTRY)

14. INFORMANT *Viola Wynn*
 (Address) *3524 S Market*

15. FILED *1917* *Mar 6* *Starkoff*
 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *March-3-1927*

17. I HEREBY CERTIFY, That I attended deceased from *2-25-1927* to *3-1-1927* that I last saw h. *er.* alive on *3-1-27*, 19... and that death occurred, on the date stated above, at *10 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Myocarditis
Mitral Insufficiency
Chronic Rheumatism with edema due to
Myocardial failure (duration) 11 years

CONTRIBUTORY (SECONDARY) *Chronic Rheumatism*
Non Malignant (duration) yrs. 3 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, *Illinois*

19. OPERATION PRECEDE DEATH? *yes* DATE OF *3-1-27*

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *operative - clinical*
 (Signed) *C. M. Conway*, M. D.

33 150 (Address) *Barren Hospital*

*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 *Winnington Park* DATE OF BURIAL *3-5-1926*

20. UNDERTAKER *Peoples Undertaking Co.* ADDRESS *3100 Franklin*

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.

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