

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

Do not use this space.

1. PLACE OF DEATH

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

Registration District No. **791**
Primary Registration District No. **1003**
(No. **5206** **Madison** St.)

File No. **19397**
Registered No. **5838**
St. _____ Ward _____

2. FULL NAME

(a) Residence No. **5206 Madison** St., _____ 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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **Wh** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **single**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan 2nd 1919**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
9 4 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **School Bus Driver**
(b) General nature of industry, business, or establishment in which employed (or employer) **95 A 715 D 571**
(c) Name of employer _____

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

10. NAME OF FATHER **Walter Spring**

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

12. MAIDEN NAME OF MOTHER **Madge Howell**

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

14. Informant (Address) **Walter Spring 5206 Madison**

15. FILED **31** 19 **28** **May** Registrar **Walter Spring**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 30 1928**

17. I HEREBY CERTIFY That I attended deceased from **Feb 9**, 19 **28**, to **May 29**, 19 **28**, that I last saw him alive on **May 29**, 19 **28**, and that death occurred, on the date stated above, at **6:27** a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ch. inf. involving Aortic valve. Aortic Insufficiency Duration - (?) Decompensation
(duration) yrs. **4** mos. ds.

CONTRIBUTORY (SECONDARY) **Ch. Inf Rheumatism, Hemeral Anasarca**
(duration) yrs. **4** mos. ds.

18. WHERE WAS DISEASE CONTRACTED **Mo**
IF NOT AT PLACE OF DEATH? **Mo**

DID AN OPERATION PRECEDE DEATH? **No** DATE OF _____

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
(Signed) **Edw. B. Finnan**, M. D.

(Address) **3718 Jennings Rd.**

*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 **Cabary** DATE OF BURIAL **June 4 1928**

20. UNDERTAKER **Walter Spring** ADDRESS **5525 Easton**

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.

WHILE FILLING IN THIS FORM, BE CAREFUL TO OBTAIN THE CORRECT INFORMATION FROM THE NEAREST RELATIVE OR NEAREST FRIEND OF THE DECEASED.

King Saw