

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

Do not use this space.

12152

1. PLACE OF DEATH

County St. Louis
Township Central
City St. Louis

Registration District No. 789
Primary Registration District No. 60338
(No. 6313, Derby Ave.)

File No. _____
Registered No. 15
St. _____ Ward _____

2. FULL NAME

Darrell D Spurgeon

(a) Residence. No. 6313 Derby Ave. St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 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) Dec 12 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
2 28 26

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Jacob Spurgeon

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Highgate
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Geneva Duncan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Missouri

14. INFORMANT Mr. Jacob Spurgeon
(Address) 6313 Derby Ave

15. FILED 3/10, 1929 Roll D. Dracy, M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 10 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-7, 1929, to 3-10, 1929 that I last saw him alive on 3-9, 1929, and that death occurred, on the date stated above, at 6A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia
1000
(duration) yrs. mos. da. 3 days

CONTRIBUTORY (SECONDARY) Angostin / Temp. Cold
(duration) yrs. mos. da. _____

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, at Home

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Symptoms

(Signed) D. M. Flynn, M.D.
3/10, 1929 (Address) 3722 21st St Grand

*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 Memorial Park Cem DATE OF BURIAL 3-11 1929

20. UNDERTAKER Geo. L. Pleitach ADDRESS 5966 Eastern

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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