

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

Do not use this space.

663

**1. PLACE OF DEATH**

County DeWitt Registration District No. 266 File No. 83  
 Township Wagonwheel Primary Registration District No. 4164 Registered No. 83  
 City Salem Mo. (No. ) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** William Clarence Sprague

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. 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 Mrs Sprague 1872

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 16<sup>th</sup> 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
57 11 22

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work R.R. Conductor  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer Missouri R.R. Co.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carroll Co Mo.

10. NAME OF FATHER Luther Sprague

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

12. MAIDEN NAME OF MOTHER Isabelle Goodfellow

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

14. INFORMANT Sue Montague (Address) Salem Mo.

15. FILED 1/19 1930 H. C. Rudolph, Jr., REGISTRAR

**2. MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 8<sup>th</sup> 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1919 to Jan 8<sup>th</sup> 1930 that I last saw him alive on Jan 2<sup>nd</sup> 1930, and that death occurred, on the date stated above, at 12 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Endocarditis, chronic  
92 D  
1910 (duration) 12 yrs. mos. ds.

CONTRIBUTORY Chronic Alcoholism (SECONDARY) (duration) 20 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? no

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Usual Physical

(Signed) W. H. Rudd, M. D. (Address) Salem, Mo.

\*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 Cedar Grove Cemt DATE OF BURIAL 1/10 1930

20. UNDERTAKER H. D. Hobson ADDRESS Salem Mo.

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.

10 2  
1  
2  
13

1-1000  
2-1000

100  
100  
100

15

100