

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

Do not use this space.

2537

1. PLACE OF DEATH

County... Missouri Registration District No. 789 File No.
 Township... Central Primary Registration District No. 6033 B Registered No. 18
 City... Weldon No. 3718 Jennings St. _____ Ward)

2. FULL NAME

~~Walter~~ Henry Springer
 (a) Residence. No. 6822 Capriotti Ave. Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Springer
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 6, 1857
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 5 27
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Carpenter
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
 10. NAME OF FATHER Carl Springer
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER Don't know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Germany

14. INFORMANT Mrs Emma Hombkamp
 (Address) Lawe Cour. Mo.

15. FILED 1/18 1930 W. D. Grey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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 16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 3 19 30
 17. I HEREBY CERTIFY, that I attended deceased from _____, 19____, to _____, 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
93c
95B (duration) yrs. mos. ds.
 CONTRIBUTORY Acute dilatation of the heart. (duration) yrs. mos. ds.
 (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED? 9019
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? yes
 WHAT TEST CONFIRMED DIAGNOSIS? autopsy
 (Signed) John Starnes, M. D.
1/4, 1930 (Address) House of Emma C.

*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 Valhalla Cemetery DATE OF BURIAL 1-18 1930
 20. UNDERTAKER Geo. L. Pleitsch ADDRESS 5966 Easton Ave.

CAUSE OF DEATH in plain terms, so that it may be properly understood.

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