

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

Do not use this space.

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OCT 31 1930

1. PLACE OF DEATH

County St. Louis
Township Central
City St. Louis (No. _____)

Registration District No. 1175
Primary Registration District No. 5999

File No. _____
Registered No. 5
St. _____ Ward)

2. FULL NAME

(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 4 yrs. 6 mos. ds. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female White Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 19 1930

17. I HEREBY CERTIFY, that I attended deceased from Sept 19, 1930, to Sept 19, 1930, that I last saw him alive on Sept 19, 1930, and that death occurred, on the date stated above, at _____ m.

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

Frank Spurling

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Gastritis
1100

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Oct 16 - 1864

7. AGE

YEARS

MONTHS

DAY

If LESS than 1 day, _____ hrs. or _____ min.

65

11

3

8. OCCUPATION OF DECEASED

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

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

(duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. J. Clarenbach, M. D.

9/20 .1930 (Address) Wright City, 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.

10. NAME OF FATHER

Ernest Paulman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER

Heinrich

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY) Germany

14. INFORMANT (Address) Herman Spurling
Forest Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Memorial Park

DATE OF BURIAL

Sept 22 1930

15. FILED 9/20, 1930

Accidentally
REGISTRAR

20. UNDERTAKER

J. Paulman

ADDRESS

Wentzells
Mo.

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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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County St Charles Registration District No. 1173- File No.
 Township Cuivre Primary Registration District No. 5999 Registered No.
 City (No.) St. Ward (No.)

2. FULL NAME Louise Bernadine Spurling
 (a) Residence No. St. Ward 7
 (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 9/20 30 W Caldwell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 19 1930

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., that I last saw him 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute bacitris
error in diet

CONTRIBUTORY Error in diet (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH? DATE.....
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed)....., M. D.
 , 19 (Address)

*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 DATE OF BURIAL
 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

CAUSE OF DEATH should be stated EXACTLY. PHYSICIAN should state statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-30914