

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

Do not use this space.

19017

1. PLACE OF DEATH

County Buchanan Registration District No. 85
 Township Primary Registration District No. 1001
 City St. Joseph (No. Missouri Methodist Hospital) St. Ward)

File No.
 Registered No. 642

2. FULL NAME

George W. Spooner
 (a) Residence, No. 505 Middleton St. St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 35 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 Gertrude Spooner
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 22, 1882
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
52 8 24
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Broom maker.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Blind Crafts.
 10. Date deceased last worked at this occupation (month and year) 1935 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Carrollton, Mo.

FATHER 13. NAME James Spooner

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown.

MOTHER 15. MAIDEN NAME Hattie E. Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown.

17. INFORMANT (ADDRESS) Mrs. Gertrude Spooner
505 Middleton St.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park Cem. DATE June, 18, 1935

19. UNDERTAKER (ADDRESS) Walter Meile
1302 Faraon St. St. Joseph, Mo.

20. FILED JUN 18 1935, John R. Bender
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June, 16, 1935

22. I HEREBY CERTIFY, That I attended deceased from June 9th to June 16th, 1935.
 I last saw him alive on June 15th, 1935. Death is said to have occurred on the date stated above, at 4.35m. P.M.
 The principal cause of death and related causes of importance were as follows:

Acute Cellulo-lymphadenitis of left thigh Date of onset ?
Septicemia 101
 Other contributory causes of importance:

Name of operation Incision of drainage Date of 17
 What test confirmed diagnosis? Was there an autopsy? 17

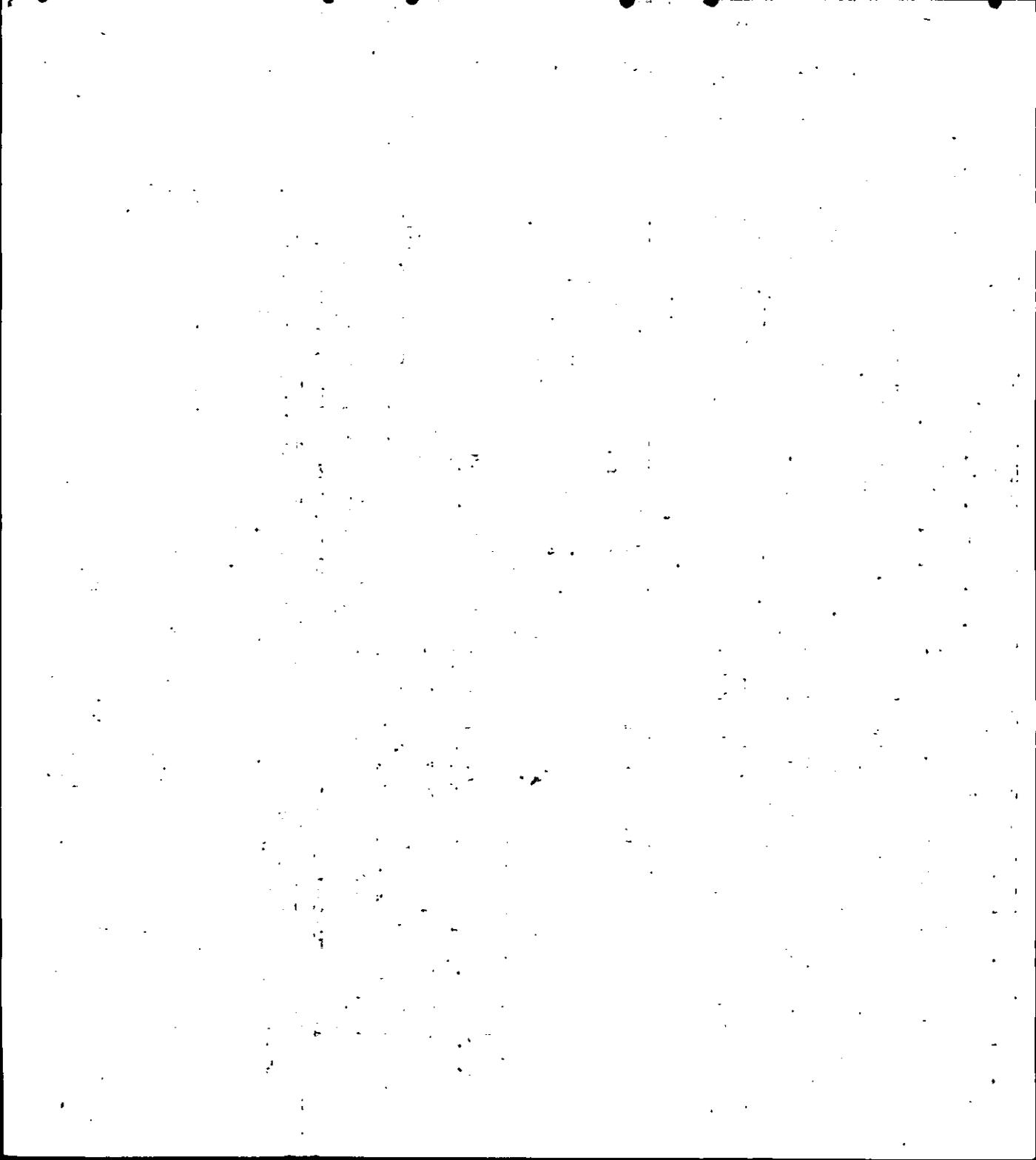
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? 17
 If so, specify Septicemia
 (Signed) Dr. J. C. ... M. D.
 (Address) Corby Bldg., St. Joseph, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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 Buchanan Registration District No. 85

Township

City St Joseph

Primary Registration District No. 1001

(No. Methodist Hospital)

File No.

Registered No. 642

Ward)

2. FULL NAME

(a) Residence, No. George W. Spooner St. 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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.
52 8 24

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 8-8-1931 John R. Bender Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 16 1935

22. I HEREBY CERTIFY, That I attended deceased from

to 19

I last saw h. alive on 19 Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Acute Cellulo-lymphadenitis

Date of onset

do not know. Cause unknown

Other contributory causes of importance:

Septicemia

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. J. Egan M. D.

(Address) Carlyle Bldg, St Joe

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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