

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

Do not use this space.

OCT 25 1935

30286

1. PLACE OF DEATH

County Ozark
Township Bayou
City Bakersfield (No. _____) St. _____ Ward _____

Registration District No. 647
Primary Registration District No. 5857

File No. _____
Registered No. _____

2. FULL NAME H. C. Spoon

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

Length of residence in city or town where death occurred 50 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 Eliza Spoon

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 19, 1861

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	74	2	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Rolla,
(STATE OR COUNTRY) Missouri.

10. NAME OF FATHER Fred Spoon

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. Mary Coble, (Daughter)
(Address) Douthat, Oklahoma.

15. FILED 9-6-35 C.A. Beach
19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) September 6, 1935

17. I HEREBY CERTIFY, That I attended deceased from September 3, 1935 to September 5, 1935, and that I last saw him alive on September 5, 1935, and that death occurred, on the date stated above, at 2:00 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

8221

(duration) _____ yrs. mos. 3 ds.

CONTRIBUTORY Age
(SECONDARY)

(duration) _____ yrs. mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Deborah Joan M. D.

Sept. 6, 1935 (Address) Bakersfield, Missouri.

*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 Spoon Cemetery DATE OF BURIAL Sept. 7, 1935

20. UNDERTAKER None ADDRESS _____

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.

PARENTS

