

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.

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

**REC'D AUG 26 1938**

26773  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Washington Registration District No. 887  
 (b) Township Liberty Primary Registration District No. 181 Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. Mattie J. Sprunger 165 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>♀</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widow</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 19 1862</u>		
7. AGE YEARS <u>76</u>	MONTHS <u>11</u>	DAYS <u>18</u> If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <input checked="" type="checkbox"/>	
	9. Industry or business in which work was done, as 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) <u>Washington Mo</u>		
FATHER	13. NAME <u>William Boss</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Washington Mo</u>	
MOTHER	15. MAIDEN NAME <u>Barabiah Beaman</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Franklin Mo</u>	
17. INFORMANT (ADDRESS) <u>Ruth Sprunger</u> <u>Washington Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Gate Chapel</u> DATE <u>July 21 1938</u>		
19. FUNERAL DIRECTOR (ADDRESS) <u>Stark</u> <u>Potomac Mo</u>		
20. FILED <u>July 30 1938</u> <u>G. J. Crosswell</u> Local Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 9 1938

22. I HEREBY CERTIFY That I attended deceased from May 27 1938 to July 9 1938  
 I last saw her alive on July 2 1938. Death is said to have occurred on the date stated above, at 2:45 m.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral Hemorrhage Date of onset \_\_\_\_\_  
8201  
 Other contributory causes of importance:  
Atherosclerosis

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? W  
 If so, specify \_\_\_\_\_  
 (Signed) M. J. Crosswell, M. D.  
 808 (Address) Latent Mo

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**STATEMENT BY LICENSED EMBALMER**

I, \_\_\_\_\_, Licensed Embalmer No. \_\_\_\_\_  
hereby certify that the body recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
\_\_\_\_\_ L. E. \_\_\_\_\_  
No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

26773  
Do not use this space.

1. PLACE OF DEATH

(a) County Washington Registration District No. 887  
 (b) Township Liberty Primary Registration District No. 6181 Registered No. ....  
 (c) City ..... (d) Street No. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Mattie J. Springee  
 (a) Residence, No. .... St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED was

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.  
76 11 18

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife  
 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)

FATHER 13. NAME  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Sept 14 1938 G. F. Creswell Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 9 1938

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said

I last saw h... alive on ..., 19... to have occurred on the date stated above, at ... m.

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

Date of onset

Other contributory causes of importance:

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) G. F. Creswell, M. D. (Address) Palosi mo

SUPPLEMENTARY

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. DISTRICTS SHALL NO. RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

