

U.S.G. MAY 16 1939

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

14435
Do not use this space.

1. PLACE OF DEATH *Camden*
 (a) County *Camden* Registration District No. *117*
 (b) Township *Wesley* Primary Registration District No. *5167* Registered No. _____
 (c) City *Camdenton* (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. da. (f) How long in U. S. if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME *Gordon Wesley Spangler*
 (a) Residence, No. *153* *Wesley City, Missouri* *Wesley City, Missouri*
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 *Jessie Spangler*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 8 - 1904*

7. AGE YEARS *34* MONTHS *17* DAYS *25* If LESS than 1 day, _____ hrs. or _____ min.

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. *Truck line*
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years, months, and days) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Wesley City, Mo.*

13. NAME *Chas Franklin Spangler*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Hancock, O.*

15. MAIDEN NAME *Grace Matilda*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bradford, Ohio*

17. INFORMANT (ADDRESS) *Jessie Spangler, Wesley City, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Wesley City, Mo.* DATE *April 4, 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Banbraw-Wobary, Camden, Mo.*

20. FILED *May 9, 1939* *Jessie Miller, Local Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 3 4, 1939*

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at *6:20 p.m.*
 The principal cause of death and related causes of importance were as follows:
Hemorrhage of Bowel
Carcinoma
 Other contributory causes of importance: _____
 Name of operation _____ Date of _____
 What test confirmed diagnosis? *Clinical* 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 *newark, Mo.*

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) *E. G. Wobary, M.D.*, M. D.
 (Address) *86 Wobary-Coroner*

Date of onset

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.

46

RECEIVED
District Health Officer No. 8
District File Number 7-39-808
Date Filed 5-12-29

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Alto Banksuit Wood*

Licensed Embalmer No. *2488*

P. O. Address *Camden, N.J.*

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.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

14433-
Do not use this space.

1. PLACE OF DEATH

(a) County Camden Registration District No. 117
 (b) Township Osage Primary Registration District No. 2167
 (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 Gordon Wesley Spangler

(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 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.
34 7 26

OCCUPATION
 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.
 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____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4 - 4 1939

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:

Hemorrhage of stomach Date of onset

Other contributory causes of importance:

Carcinoma of stomach

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) T. E. Claiborn Local

(Address) Camden mo

SUPPLEMENTARY

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.

PHYSICIANS SHOULD STATE EXACTLY. PHYSICIANS SHOULD STATE EXACTLY. PHYSICIANS SHOULD STATE EXACTLY.

