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.

REC'D MAY 19 1939

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

15194
Do not use this space.

1. PLACE OF DEATH
(a) County Jasper
(b) Township or City JOPLIN
(c) Webb City
Registration District No. 417
Primary Registration District No. 3021
Registered No. 32
(d) Street No. 204 N. WEBB. 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 162 Mollie W. Spracklen
(a) Residence, No. 204 N. Webb St.
(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 Female
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 Edwin E. Spracklen
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 13 1863
7. AGE YEARS 75 MONTHS 6 DAYS 6 If LESS than 1 day, ...hrs. or ....min.

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. At Home
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) Manhattan Kansas

FATHER
13. NAME J. A. Rice
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

MOTHER
15. MAIDEN NAME Flavilla St Ledge
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

17. INFORMANT (ADDRESS) Marvin R. Spracklen Webb City, Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Webb City Cem DATE Apr 22 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Webb City Und Co Webb City, Mo
20. FILED APR. 21. 39 19 P. L. Pritchett M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 19, 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to 4/19, 1939
I last saw her alive on 4/19, 1939. Death is said to have occurred on the date stated above, at 4:30 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Anginal Pectoris	
Instantaneous	

Other contributory causes of importance: Senility 94 a

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? no
If so, specify .....
(Signed) B. G. Dumbaud, M. D.
377 (Address) Webb City, Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 6-5-39-1012
Date Filed MAY 2 1939

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

Signed Clayton M. Johnston
Licensed Embalmer No. 3,922
P. O. Address Webb City, Mo

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

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