

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**

32393  
Do not use this space.

**1. PLACE OF DEATH**

(a) County GREENE Registration District No. 316  
 (b) Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 684  
 (c) City SPRINGFIELD (d) Street No. Burge Hospital 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. Hurley, Mo. 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF Clavin Spears  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 20 1906  
 7. AGE YEARS 33 MONTHS 3 DAYS 15 IF LESS than 1 day, ..... hrs. or ..... min.

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

FATHER 13. NAME Claude Barty  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clark, Mo.

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

17. INFORMANT (ADDRESS) Mrs Maudie Barty, Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE North Mo. DATE Sept 7, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin Johnson, Springfield, Mo.

20. FILED Sept 7, 1939 Chas. A. Berger Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 5, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1939 to Sept 5, 1939  
 I last saw him alive on Sept 5, 1939 Death is said to have occurred on the date stated above, at 11:15 P.M.  
 The principal cause of death and related causes of importance were as follows:

Typhoid fever Date of onset Aug 12, 1939

Other contributory causes of importance:

Pregnancy - Delivery Date Aug 20, 1939

Name of operation none Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? no

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) Fred R. Farthing M. D.  
 (Address) Med Arts Bldg.

**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..... *Lewis G. Scharpf*.....

Licensed Embalmer No..... *3802*.....

P. O. Address..... *Springfield, Mo*.....

**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.**

X