

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.

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH: 22000
(a) County 1
(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

8. (a) PRINT FULL NAME Asa Springer 165
8. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex M 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Barney Springer 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Aug 6 1879
(Month) (Day) (Year)

8. AGE: Years 60 Months 4 Days 15 If less than one day hr. _____ min. _____

9. Birthplace Nebo Mo. (City, town, or county) (State or foreign country)

10. Usual occupation City Dept. of Streets

11. Industry or business Wood River, Mo.

12. Name John Springer

13. Birthplace Pike County Mo. (City, town, or county) (State or foreign country)

14. Maiden name Nancy Springer

15. Birthplace BRISTOW Mo. (City, town, or county) (State or foreign country)

16. (a) Informant's own signature F. L. Springer

(b) Address Wood River, Mo.

17. (a) Funeral (b) Date thereof Dec 21-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Altan Ill.

18. (a) Signature of funeral director Robt. H. Steeper

(b) Address Altan Ill.

19. Dec 22 1939 (b) J. P. [Signature]
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Madison
(c) City or town Wood River NR
(If outside city or town limits, write "RURAL")
(d) Street No. 437 Whitelaw Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 21
year 1939 hour 10⁰³ minute _____ P. M.
21. I hereby certify that I attended the deceased from 12-16-39
_____, 19____, to 12-21- 1939
that I last saw him alive on 12-21 1939:
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Due to arterial hypertension
Due to _____
Other conditions SAH
(Include pregnancy within 3 months of death)

Major findings: Subarachnoid hemorrhage
Of operations _____
Of autopsy subarachnoid hemorrhage

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature M. Anderson (M. D. or other) _____
Address BARNES HOSPITAL Date signed 12-22

PHYSICIAN

Underline the cause to which death should be charged statistically

See affidavit # 241 in misc file

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

Robt. H. Steeper

Licensed Embalmer No.

2724

P. O. Address

Alton Iles

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.