

Registration District No. 816

Primary Registration District No. 4492

Registrar's No. 11

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Chaffee
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community 26 years

8. (a) PRINT FULL NAME Mathewine Freda Spradling

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife John Spradling 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased July 10 1875
(Month) (Day) (Year)

8. AGE: Years 64 Months 8 Days 11 If less than one day hr. ✓ min. _____

9. Birthplace Columbia Ill. (City, town, or county) (State or foreign country) 1

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name Jake Grammisch
13. Birthplace Don't Know (City, town, or county) (State or foreign country) 9
14. Maiden name E. Ith
15. Birthplace Don't Know (City, town, or county) (State or foreign country) 9

16. (a) Informant's own signature Ruth Spradling
(b) Address Chaffee Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Union Park Cem Chaffee Mo

18. (a) Signature of funeral director Displinghoff Hubbers
(b) Address Chaffee Mo

19. (a) 3/22-40 (Date received local registrar) (b) W.D. Finney (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott
(c) City or town Chaffee (If outside city or town limits, write "RURAL")
(d) Street No. 120 Cook Ave (If rural, give location)
(e) If foreign born, how long in U. S. A. ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 21 year 1940 hour 2 minute P M.

21. I hereby certify that I attended the deceased from 1938, 1938, to 3-21, 1940 that I last saw her ✓ alive on 3-20, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis Duration 5 yrs

Due to Carcinoma Uterus 3 yrs

Due to _____
Other conditions (Include pregnancy within 3 months of death) HP

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

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? _____

23. Signature W.D. Finney (M. D. or other) 1
Address Brk Bldg Chaffee Date signed 3/22-40
Mo 40

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.

RECEIVED

District Health Officer No. 2

District File Number 440-84

Date Filed 4/3/40

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 *Wm. Duglinghoff*

Licensed Embalmer No. 3242

P. O. Address *Chaffee, 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.