

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **27749**  
Registrar's No. **3383**USE 1939  
Registration District No. **399**Primary Registration District No. **1002**

## 1. PLACE OF DEATH:

(a) County Lafayette, Jackson  
 (b) City or town Wagon City, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Mercy Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution two days  
 (Specify whether  
 In this community non-Resident  
 years, months or days)

3. (a) PRINT FULL NAME Robert Lee Spring 6523. (b) If veteran, name war. — 3. (c) Social Security No. —4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced —6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years7. Birth date of deceased Nov 11 1938  
(Month) (Day) (Year)8. AGE: Years 1 Months 9 Days 17 If less than one day — hr. — min.9. Birthplace Higginsville, Mo.  
(City, town, or county) (State or foreign country)10. Usual occupation Infant11. Industry or business —12. Name John Wm Spring13. Birthplace Higginsville Mo.  
(City, town, or county) (State or foreign country)14. Maiden name unknowen15. Birthplace "  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature John Wm Spring(b) Address Higginsville, Mo.17. (a) Burned (b) Date thereof Aug. 29, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Higginsville, Mo.18. (a) Signature of funeral director R. N. Zader(b) Address Higginsville, Mo.19. (a) Aug. 28, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lafayette  
 (c) City or town Higginsville, Mo.  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. — (If rural, give location)  
 (e) If foreign born, how long in U. S. A. — years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28  
year 1940 hour 1 minute 50 P.M.21. I hereby certify that I attended the deceased from Aug 28, 1940, to Aug 28, 1940;  
that I last saw him alive on Aug 28, 1940;  
and that death occurred on the date and hour stated above.Immediate cause of death Miliary tuberculosis Duration —Due to Tubercle BacillusDue to —Other conditions Dehydration  
(include frequency within 3 months of death) toxaemiaMajor findings: —  
Of operations —Of autopsy px. nodules spleen  
hrew. Casous tuberc lymph22. If death was due to external causes, fill in the following: Stand.(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?  
360 (Specify type of place) (e) Means of injury 123. Signature W. B. Soderberg (M. D. or other) —Address 1316 Pm Rd Date signed Aug 28

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.

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**