

Registration District No. 589

Primary Registration District No. 4347

Registrar's No. 26

1. PLACE OF DEATH

(a) County Montgomery
(b) City or town Jonesburg
(If outside city or town limits, write "RURAL" and name of township)
(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)
In this community all of life years, months or days

3. (a) PRINT FULL NAME Lebert Jean Spires 11-2

3. (b) If veteran, name war 0 3. (c) Social Security No. 0

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife 0 6. (c) Age of husband or wife If alive 0 years

7. Birth date of deceased aug 25 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 17 hr. min.

9. Birthplace Jonesburg Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation 0

11. Industry or business 0

MOTHER FATHER
12. Name Ralph Spires
13. Birthplace Montgomery County 0
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Cunn
15. Birthplace Jonesburg Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Ralph Spires
(b) Address Jonesburg Mo

17. (a) _____ (b) Date thereof aug 26 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jonesburg

18. (a) Signature of funeral director Earl A Harding

(b) Address Jonesburg Mo

19. (a) Aug. 26-40 (b) 1 Mary Lou Fleener
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Montgomery
(c) City or town Jonesburg
(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? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 26
year 1940 hour 1 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Aug 25
1940 to Aug 26 1940
that I last saw him alive on Aug 25 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth
(6 1/2 months)

Due to 159
Other conditions (include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy none

Duration
PHYSICIAN
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) 1
(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?
800 9 (Specify type of place)
While at work? _____ (e) Means of injury 1

23. Signature James O. Helton (M. D. or other)
Address New Florence Mo Date signed 8/27/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.