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FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30891

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 3454

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5300 Gardener
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)

In this community 1 wk

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Clay

(c) City or town No. Kansas City (Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Route 5 (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Goben D Sprague GOBEN D. SPRAGUE

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Helen M. Sprague

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Nov. (Month) 30 (Day) 1870 (Year)

8. AGE: Years 69 Months 9 Days 2 If less than one day ..... hr. ..... min.

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

10. Usual occupation Retired 0

11. Industry or business 0

FATHER
12. Name James E. Sprague
13. Birthplace unknown (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Sarah J. Doyle
15. Birthplace unknown (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs. Helen M. Sprage

(b) Address ROute 5 No. Kansas City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director Morton Funeral Home

(b) Address North K.C. Mo.

19. (a) Sept. 3, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day 9.2.40

year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 11 45 A. ..... 19 ..... to ..... 19 .....;

that I last saw alive on ..... 19 .....;

and that death occurred on the date and hour stated above.

Immediate cause of death ..... Duration

Death by hanging

Due to .....

Other conditions 165
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy .....

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) Suicide

(b) Date of occurrence DO NOT KNOW

(c) Where did injury occur? K.C. (City or town) (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury 5

23. Signature [signature] (M. D. or other)

Address K.C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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. 267

working under my personal supervision.

Signed.....

Licensed Embalmer No. 29 79

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.