

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32683
 Registrar's No. 104

Registration District No. 409 Primary Registration District No. 4343

1. PLACE OF DEATH:
 (a) County NEWTON
 (b) City or town NEOSHO
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution REYNOLDS HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 HOURS
 (Specify whether in this community years, months or days)

3. (a) PRINT FULL NAME LAVESTA VIOLA SPOON
 3. (b) If veteran, name war NONE
 3. (c) Social Security No. NONE

4. Sex FEM. 5. Color or race W
 6. (a) Single, widowed, married, divorced SINGLE
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased DECEMBER 16 1938
 (Month) (Day) (Year)

8. AGE: Years 1 Months 8 Days 19
 If less than one day hr. _____ min. _____

9. Birthplace NEWTON COUNTY MISSOURI
 (City, town, or county) (State or foreign country)

10. Usual occupation INFANT

11. Industry or business _____
 12. Name JOHN SPOON
 13. Birthplace CONAMA MISSOURI
 (City, town, or county) (State or foreign country)
 14. Maiden name BEATRICE HARRINGTON
 15. Birthplace VALLEON OKLAHOMA
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John M. Spoon
 (b) Address NEOSHO MO.

17. (a) BURIAL (b) Date thereof 9-5-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation GILSON CEMETERY

18. (a) Signature of funeral director Earley Thompson
 (b) Address Neosho Missouri

19. (a) 10-4-40 (b) Orval A. Salter, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County NEWTON
 (c) City or town NEOSHO
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month 5 day SEPT
 year 1940 hour 2:30 minute 2 A. M.

21. I hereby certify that I attended the deceased from Sept 4, 1940, to Sept 5, 1940;
 that I last saw him alive on Sept 4, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Ellis Colitis
 Duration _____

Due to In dying condition
 Due to when I saw the child

Other conditions (include pregnancy within 8 months of death) _____

Major findings: Of operations none
 Of autopsy none
 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?
543
 While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature R. L. Lacey (M. D. or other) 10-3-40
 Address Neosho Mo Date signed _____

RECEIVED

District Health Officer No. 6,

District File Number 1040-2706

Date Filed ~~OCT 11 1940~~ OCT 11 1940

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 *Gail K Gay*.....

Licensed Embalmer No. *4155*.....

P. O. Address *Neosho, 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.