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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34215

Registration District No. 791 Primary Registration District No. 1003 Registrar's No. 8912

FILED NOV 16 1940

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: St. Luke's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County

(c) City or town Fieldon NR
(If outside city or town limits, write "RURAL")

(d) Street No. Rural
(If rural, give location)

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

3. (a) PRINT FULL NAME Edward Springman

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Hazel

6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased Sept. (Month) 9 (Day) 1876 (Year)

8. AGE: Years 64 Months 1 Days 20 If less than one day hr. min.

9. Birthplace Jersey Co. (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Henry Springman
13. Birthplace Hanover (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Christina Schaff
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edw. Springman
(b) Address Fieldon, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/29/40 (Month) (Day) (Year)
(c) Place: burial or cremation Jerseyville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Ave.

19. (a) OCT 29 1940 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 29th year 1940 hour 6 minute 05 A.M.

21. I hereby certify that I attended the deceased from 8 pm 10-28-40, 19__, to 6 am 10-29-40, 19__; that I last saw him alive on 10-29-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary thrombosis	4 yr.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy Coronary calcification & interventricular infarction	

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)
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. Baumgarten Jr. (M. D. or other) MD
Address % St. Luke's Hosp. Date signed 10-29-40

(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.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1122

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.