

Registration District No. **85** Primary Registration District No. **1001**

Registrar's No. **1157**

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph,
(c) Name of hospital or institution St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hours
In this community 1 yr. 4 mo. 7 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town Saint Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2214 North 4th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME SHIRLEY JEAN SPINNER
3. (b) If veteran, name war none 3. (c) Social Security No. none

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 31
year 1940 hour 8 minute 45 P. M.

4. Sex female 5. Color or race white 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 June 24 1939
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from October 31
October 31, 1940, to October 31, 1940,
that I last saw her alive on October 31, 1940
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
1 4 7 _____ hr. _____ min.

Immediate cause of death
Acute Bronchopneumonia 3 days
Duration

9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____

MOTHER FATHER { 12. Name Gilbert Spinner
13. Birthplace Rushville Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Barrett
15. Birthplace Falls City, Nebraska
(City, town, or county) (State or foreign country)

Of autopsy Acute Bronchopneumonia
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Gilbert Spinner
(b) Address 2214 North 4th Street
17. (a) Suburial (b) Date thereof 11-3-40
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation Sugar Creek
18. (a) Signature of funeral director Fleeman & Son, Inc.
(b) Address 1946 Colburn St. St. Joseph
19. (a) Nov 7, 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

(Specify type of place) (c) Means of injury _____
While at work? _____
23. Signature [Signature] (M. D. or other) _____
Address 202-3 Physicians Bldg Date signed 11-1-40
St. JOSEPH

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

107a

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: *Carl W. Harris*

Licensed Embalmer No. *3955*

P. O. Address *St Joseph,*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **34888**
Registrar's No. **1157**

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **1157**

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

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **St Joseph**
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether

In this community..... years, months or days)

3. (a) PRINT FULL NAME **Shirley Jean Spinner**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 4 7 h min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant..... (b) Address.....

17. (a) (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) **12-13-40** (Date received local registrar) (b) **H. Nestlebaum** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (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 **Oct** day **31** year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death **acute Bronch**

pneumonia

Due to **No complications**

Due to.....

Other conditions..... (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).....

(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?

While at work..... (Specify type of place)

(e) Means of injury.....

23. Signature **John M. Hughes** (M. D. or other) Address **Physician's Office** Date signed **12-12-40**

SUPPLEMENTAL

