

FD-22159

RECEIVED FEB 17 1941

Registration District No. 103 Primary Registration District No. 4757 Registrar's No. _____

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

1. PLACE OF DEATH:
(a) County New Madrid
(b) City or town Morehouse Missouri
(If outside city or town limits, write "RURAL" and name of township)
(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 22 days (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Marion Spurlin Jr.
3. (b) If veteran, name war Infant 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 12 27 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 22 hr. min.

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

10. Usual occupation None

11. Industry or business None

MOTHER FATHER
12. Name Marion Spurlin
13. Birthplace Mill Shoals Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Mirtie Pennington
15. Birthplace Crowder, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Marion Spurlin
(b) Address Morehouse, Mo.

17. (a) Burial (b) Date thereof 1/20/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation McMullin, Mo.

18. (a) Signature of funeral director [Signature]
(b) Address Sikeston, Missouri

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County New Madrid
(c) City or town Morehouse
(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.? 0 years.

7230

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 19
year 1941 hour 2 minute _____ P.:M.

21. I hereby certify that I attended the deceased from Jan 19 1941 to Jan 19 1941;
that I last saw him alive on Jan 19 1941
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Due to [Signature]
Due to [Signature]

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

Major findings: Of operations [Signature] Of autopsy [Signature]
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 None
(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? _____

23. Signature [Signature] (M. Doctor)
Address Sikeston Date signed 2-5-41

REC'D

REC'D BY THE CLERK

1911

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

Body Not Embalmed

Registered Apprentice No.

working under my personal supervision.

Signed

Harney Johnson

Licensed Embalmer No.

3704

P. O. Address

Seaton, Mo

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

State File No. 3524

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 603

Primary Registration District No. 4357

Registrar's No.

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Morehouse
(If outside city or town limits, write "RURAL" and name of township)
(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

Marion Spurlin, Jr.

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex M 5. Color or race W

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

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 min.
22

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) Month 30 1946 (b) Mrs John Parvish (c) (Date received local registrar) (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 Jan day 19 year 1946 hour..... minute..... M.

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

Due to.....
Due to.....

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

Major findings: Of operations.....

Of autopsy.....

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 M. G. Anderson (M. D. or other)

Address Beaton Mo Signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

