

FILED APR 28 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

12304

## 1. PLACE OF DEATH

County Texas Registration District No. 866 107 File No. 0  
 Township Current Primary Registration District No. 6146 Registered No. 0  
 City                      (No. 1)                      St.                      Ward                     

## 2. FULL NAME

Jue) Deloris Spurgeon  
 (a) Residence, No. Texas Co mo St. Rural (If nonresident, give city or town and State)  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF                     

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-20-1938

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
2 10 18

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)                     

11. Total time (years) spent in this occupation                     

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Raymondville MO

13. NAME Wellington Spurgeon

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mountain MO

15. MAIDEN NAME Leone Shipp

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Licking MO

17. INFORMANT Leone Shipp Spurgeon

18. BURIAL, CREMATION, OR REMOVAL PLACE Boonville MO DATE 3-10-41

19. UNDERTAKER Smith & Ferguson

20. FILED Mar 28, 1941 Maggie E. Murphy Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 8, 1941

22. I HEREBY CERTIFY, That I attended deceased from Mar 6, 1941, to Mar 8, 1941

I last saw her alive on Mar 8, 1941. Death is said to have occurred on the date stated above, at 6:30 p.m.

The principal cause of death and related causes of importance were as follows:

Double Broncho pneumonia Date of onset                     

Other contributory causes of importance:

Name of operation                      Date of                     

What test confirmed diagnosis?                      Was there an autopsy?                     

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?                      Date of injury                     , 19                    

Where did injury occur?                      (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury                     

Nature of injury                     

24. Was disease or injury in any way related to occupation of deceased?                     

If so, specify                     

(Signed) W. L. Beed, M. D.

(Address) Licking

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 impo

WHITE PAPER, WITH OVERPRINTED MATTER THIS IS A PERMANENT RECORD

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RECEIVED

District Health Officer No. 5,

District File Number. 481466

Date Filed \_\_\_\_\_

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 102304

Registration District No. 866

Primary Registration District No. 6146

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County DeKalb  
(b) City or town Decatur, Ga.  
(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 Juel Deloris Spurgeon

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 x  
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  
2 10 18 hr. 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 8  
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 Double Broncho pneumonia

Due to No Complications

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 J. H. Reed (M. D. or other) \_\_\_\_\_

Address Richmond Date signed 4/1/41

SUPPLEMENTAL

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

[The page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is scattered across the page and cannot be transcribed accurately.]