

FILED MAR 9 1942

State File No.

Registration District No. 347

Primary Registration District No. 3018

Registrar's No.

1. PLACE OF DEATH
(a) County Henry
(b) City or town Clinton, Mo
(c) Name of hospital or institution: Clinton General
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days) 60 years

3. (a) PRINT FULL NAME Jasper Newton McSpadden
(b) If veteran, name war _____
(c) Social Security No. _____

4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced, widowed
(b) Name of husband or wife Jane M Spadden
(c) Age of husband or wife if alive, years 4
7. Birth date of deceased Mar 24 1859
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 4
If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business _____

12. Name James M Spadden

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

14. Maiden name Juliana A Frier

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

16. (a) Informant C. G. McSpadden
(b) Address Clinton, Mo R. 2

17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof 3 1 1942
(Month) (Day) (Year)

(c) Place: burial or cremation St Paul Cemetery

18. (a) Signature of funeral director Paul Sloan
(b) Address Clinton, Mo

19. (a) Feb. 28, 1942 (b) Georgia Kitchen
(Date received local registrar) (Registrar's signature) D.K.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Henry
(c) City or town Chilhowee R 2
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 28
year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Feb 23 1942 to Feb 28 1942
that I last saw him alive on Feb 27 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Duration 5 days

Due to Generalized Arterio Sclerosis

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
Of operations 430

Of autopsy None

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) Means of injury None

23. Signature S. B. Hughes (M. D. or other) MD

Address Clinton, Mo Date signed 2/28/42

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

12
1
2

RECEIVED

District Health Officer No. 7,

District File Number 3-42-165

Date Filed 3-4-42

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 W.K. Jackson

Licensed Embalmer No. 3954

P. O. Address Seheston 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, fact should be so stated above.