S. No. 2
1—9-4-41
5-17-39
X29484

6004

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 5 1943

Registration District No. 5 Primary Registration District No. 3010 Registrar's No. 50.

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

1. PLACE OF DEATH:
(a) County: Cape Girardeau
(b) City or town: Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Francis Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 10 years 1 day

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

3. (a) PRINT FULL NAME: Charles Jerry Spies
3. (b) If veteran, name war: —
3. (c) Social Security No.: —
4. Sex: Male
5. Color or race: White
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: Feb. (Month) 17 (Day) 1933 (Year)

8. AGE: Years	Months	Days	If less than one day
9	11	27	hr. min.

9. Birthplace: Fornfelt (City, town, or county) Mo (State or foreign country)
10. Usual occupation: School boy
11. Industry or business:
FATHER 12. Name: Chas J Spies
13. Birthplace: Ill. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Delia M Young
15. Birthplace: Hilburn (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Mrs C J Spies
(b) Address: Fornfelt Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Lightner Cem Illmo Mo
18. (a) Signature of funeral director: Bispinghoff & Lubbers
(b) Address: Illmo Mo
19. (a) 2-16-43 (Date received local registrar) (b) F. W. Phelps (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2/14/43 day
year hour 4 minute 10 A.M.
21. I hereby certify that I attended the deceased from 1/2/43, 19..., to 2/14/43, 19...;
that I last saw him alive on 2/13/43, 19...;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	
Due to: —	
Due to:	
Other conditions: Nephritis (Include pregnancy within 3 months of death)	
Major findings: Of operations: None	
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): no
(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: R. E. Lee M.D. (M. D. or other) M.D.
Address: Illmo Mo Date signed 2/15/43

1014 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 343-1900

Date Filed 3-8-43

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 Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson 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.

S. No. 2B
.0M—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6004

Registration District No. ____ Primary Registration District No. 3010 Registrar's No. ____

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Francis Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 da (Specify whether
In this community 1 da
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Scott
(c) City or town Fornsfelt
(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 ____

3. (a) PRINT FULL NAME Charles Jerry Spies

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 S
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Feb (Month) 17 (Day) 1933 (Year)

8. AGE: Years 9 Months 11 Days 27 If less than one day ____ hr. ____ min.

9. Birthplace Mo (City, town, or county) ____ (State or foreign country)
10. Usual occupation School
11. Industry or business ____
MOTHER FATHER
12. Name Chas J Spies
13. Birthplace ____ (City, town, or county) Ill (State or foreign country)
14. Maiden name Delia M Young
15. Birthplace ____ (City, town, or county) Mo (State or foreign country)
16. (a) Informant ____
(b) Address ____
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director ____
(b) Address ____
19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 14
year 1942 hour 7 minute 6 m. 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.

	Duration
Immediate cause of death Broncho Pneumonia	
Due to ____	
Due to ____	
Other conditions Nephritis Chr (Include pregnancy within 3 months of death)	
Cause Tonsils	
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)
(b) 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 ____ (M. D. or other) ____
Address ____ Date signed ____