No. 2
5-42
17-39
X32878

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7444

FILED MAR 11 1943

Registration District No. 3107 Primary Registration District No. 6049 Registrar's No.

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

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town Augusta Rural [illegible] (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: / Jump

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

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

In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County St Charles 92

(c) City or town Augusta RR #2 (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 0

3. (a) PRINT FULL NAME Betty Marie Sprock

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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased 10 (Month) 11 (Day) 1929 (Year)

8. AGE: Years 13 Months 3 Days 25 If less than one day hr. min.

9. Birthplace Highridge MO (City, town, or county) 0 (State or foreign country)

10. Usual occupation HWK

11. Industry or business

FATHER
12. Name Wm Sprock
13. Birthplace Highridge (City, town, or county) MO (State or foreign country)

MOTHER
14. Maiden name Lillian Swaller
15. Birthplace Rock Creek (City, town, or county) MO (State or foreign country)

16. (a) Informant Wm Sprock

(b) Address Augusta MO

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/19/43 (Month) (Day) (Year)

(c) Place: burial or cremation Rock Creek MO

18. (a) Signature of funeral director Kurtis Undertakers

(b) Address 2906 Gravois

19. (a) 2/16/43 (Date received local registrar) (b) Calvin Clay MD (Registrar's signature)

677

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16th year 1943 hour 9 minute 30 a M.

21. I hereby certify that I attended the deceased from Jan 29 1943 to Feb 16 1943 that I last saw her alive on Feb 18 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hodgkins Disease	5 yr
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) 44	

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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature G C Johnson (M. D. or other)

Address Martinsville MO Date signed 2/16/43

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.

No. 2B
-41
288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 307 Primary Registration District No. 6049 Registrar's No. .....

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town AUGUSTA (RURAL FEMME OSAGE TWP

(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 years, months or days)

In this community 5 YRS

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County ST CHARLES

(c) City or town AUGUSTA RURAL FEMME OSAGE TWP.

(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 Betty Mariedgrock

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 Oct 11-1928 (Month) (Day) (Year)

8. AGE: Years 13 Months 2 Days ..... If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

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) ..... (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 Oct Day 7 Year 1943 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 ..... Duration

Due to .....

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? ..... (Specify type of place) (c) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY 16

7444