

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 1 1943
Registration District No. 2040

Primary Registration District No. 5756

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Marion Co
(b) City or town Highgate Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Marion
(c) City or town (Highgate) Rural
(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.

3. (a) PRINT FULL NAME

Eliza K Spurgeon

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 1

6. (b) Name of husband or wife J C Spurgeon

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased 2-23-1868
(Month) (Day) (Year)

8. AGE:

Years 75 Months 2 Days 27
If less than one day _____ hr. _____ min.

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

10. Usual occupation House wife

11. Industry or business

12. Name Thos A Bray
13. Birthplace England
(City, town, or county) (State or foreign country)
14. Maiden name Emma Wheeler
15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Ed Heiderl

(b) Address Rape Mo

17. (a) Burial (b) Date thereof 5-23-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highgate Cem

18. (a) Signature of funeral director W E Kuchler

(b) Address St James Mo

19. (a) 6-3-43 (b) Emma Bassett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 20
year 1943 hour 5:30 minute 9 M.

21. I hereby certify that I attended the deceased from April, 1943, to May 20, 1943
that I last saw her alive on May 19, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death: acute dilatation heart
Due to Pneumonia Duration 4 wks

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____
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) (e) Means of injury _____

23. Signature W E Kuchler (M. D. or other) _____
Address St James Mo Date signed _____

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

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 E Licklider

Licensed Embalmer No. *1970*

P. O. Address

St James 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, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 207 Primary Registration District No. 5256 Registrar's No. 106

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Rural
(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 (Specify whether _____)

3. (a) PRINT FULL NAME Eliza K. Spurgeon

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 _____

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

7. Birth date of deceased: Feb 23 1926
(Month) (Day) (Year)

8. AGE: Years 15 Months 2 Days _____ If less than one day _____ min.

9. Birthplace Mo.
(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 May Day 26
year 1943 hour _____ minute _____ M.

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

Immediate cause of death acute dilatation of heart

Due to Pneumonia (Bronchial)

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 Walter H. Brewer (M.D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

Wm H. Brewer

St James

5-18360