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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 14 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3041

Registration District No. 139 Primary Registration District No. 4771 Registrar's No. 1

1. PLACE OF DEATH:

(a) County Holt

(b) City or town Mound City.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt 44

(c) City or town Mound City. 1
(If outside city or town limits, write "RURAL") 0

(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 John Alva Springer.

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 Married 1

6. (b) Name of husband or wife Tebetha Jane Springer 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased April (Month) 18 (Day) 1859 (Year)

8. AGE: Years 84 Months 8 Days 13 If less than one day ..... hr. ..... min.

9. Birthplace Peoria (City, town, or county) Ill. 1 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business .....

FATHER
12. Name Jacob Springer.
13. Birthplace ..... (City, town, or county) Penn. 1 (State or foreign country)

MOTHER
14. Maiden name Samantha Willis.
15. Birthplace Unknown. (City, town, or county) 9 (State or foreign country)

16. (a) Informant Mrs John Springer.
(b) Address Mound City. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/44 (Month) (Day) (Year)
(c) Place: burial or cremation Mound City. Mo.

18. (a) Signature of funeral director Wm Crawford
(b) Address Mound City. Mo.

19. (a) 1-3-44 (Date received local registrar) (b) Pauline Lawson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day Ist, year 1944 hour 10 minute -10 a M.

21. I hereby certify that I attended the deceased from Nov 1st '43 to Jan 1st, 1944 to ....., 19....; that I last saw him alive on Jan 1st, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Uremia, Chr. Interstitial Nephritis

Due to .....

Due to .....

Other conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

Duration

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 .....

23. Signature J Chary cm (M. D. ~~or other~~)

Address Mound City Mo. Date signed 1-8-44

(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 W. H. Crawford

Licensed Embalmer No. 1824

P. O. Address Maurd City 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.