S. No. 2
M—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 24191

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 189

**1. PLACE OF DEATH:**
(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Indep. Sanit Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Hrs. (Specify whether years, months or days)
In this community 60 years.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo (b) County Jackson 48
(c) City or town Independence 4
(If outside city or town limits, write "RURAL")
(d) Street No. 915 N. Main St. 11
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Della Haines Spillman
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John Spillman 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased March 29, 1880 (Month) (Day) (Year)

8. AGE: Years 65 Months 3 Days 0 If less than one day hr. min.

9. Birthplace Clay County, Mo. (City, town, or county) (State or foreign country)
10. Usual occupation House wife
11. Industry or business

MOTHER FATHER
12. Name Charles Haines
13. Birthplace Springfield Ohio (City, town, or county) (State or foreign country)
14. Maiden name Adeline Mary Stevens
15. Birthplace Clay Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mr. John Spillman
(b) Address 915 N Main St. Inde. Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn - Indep.
18. (a) Signature of funeral director Otto Mitchell
(b) Address 310 N. Main Indep. Mo.
19. (a) 6-30-45 (Date received local registrar) (b) James Cross (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 29 year Between 4-5 o'clock P.M.
21. I hereby certify that I attended the deceased from Aug 19, 1944 to June 29, 1945; that I last saw her alive on June 26 1945, 19..; and that death occurred on the date and hour stated above.

Immediate cause of death Nephritis — Duration 30 days
Due to Cardiac Muscular Damage
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations None
Of autopsy None

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 George Thomas Twyman (M. D. or other)
Address Independence Mo Date signed 6/29/45

166-3 (Licensed Embalmer's Statement on Reverse Side)

JUN 9 1948

**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 Me

, Registered Apprentice No.

working under my personal supervision.

Signed Henry G. Mitchell

Licensed Embalmer No. 3925

P. O. Address Lindep. 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
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 449

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 189

**1. PLACE OF DEATH:**

(a) County: Jackson

(b) City or town: Independence

(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

**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

3. (a) PRINT FULL NAME: Della H. Spillman

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: M

6. (b) Name of husband or wife

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

7. Birth date of deceased: Mar. (Month) 29 (Day) 1880 (Year)

8. AGE: Years 65 Months 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

FATHER

12. Name

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

MOTHER

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 July 29 year 1945 hour minute 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.

Immediate cause of death — Duration

Due to

Due to Nephritis Acute cause unknown

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)

(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 (M.D. or other)

Address Independence Mo Date signed 7/28/45

SUPPLEMENTARY

24191