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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 10 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 24836

Registration District No. 315 Primary Registration District No. 6066 Registrar's No.

1. PLACE OF DEATH:

(a) County St. Clair

(b) City or town Roscoe Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Roscoe Rd
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City, Mo. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 8
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Arthur Clarence Springer

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex M 11

5. Color or race W

6. (a) ~~Single~~, widowed, married; divorced widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec. (Month) 23 (Day) 1861 (Year)

8. AGE: Years 83 Months 5 Days 28 If less than one day hr. min.

9. Birthplace Hillsborough (City, town, or county) Ohio 1 (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name John Springer
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Mary Boatman
15. Birthplace (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Mrs. Frankie Springer
(b) Address El Dorado Springs Mo. R#4

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23 1945 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ Mount Vernon

18. (a) Signature of funeral director Osceola Funeral Home
(b) Address Osceola Missouri

19. (a) 6/25/45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 21
year 1945 hour 6 minute 40 P.M.

21. I hereby certify that I attended the deceased from 1 1942, 19, to June 15, 1945;
that I last saw ~~him~~ alive on June 15, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma of Prostate Glands	2 years
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 516	
Of autopsy no	

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 W Richardson (M. D. ~~or other~~)
Address Piffin Mo Date signed 6/21/45

1100

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Di[illegible] Officer No. 7
Di[illegible] 7-45-775
Date Filed 8-9-45

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 J B Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola 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.