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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED** MAR 7 1946  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6224

State File No. \_\_\_\_\_  
Registrar's No. 4

Registration District No. 161 Primary Registration District No. 5594

1. PLACE OF DEATH:  
(a) County Jefferson  
(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

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO. (b) County Jefferson  
(c) City or town House Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Christina Sprock  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb. day 5  
year 1946 hour 10 A.M. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Nov. 28,  
1945 to Feb. 5, 1946  
that I last saw him alive on Feb. 5, 1946  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Merlin E. Sprock 6. (c) Age of husband or wife if alive 52 years  
7. Birth date of deceased Aug 23 (Month) (Day) (Year)

Immediate cause of death Carcinoma of right shoulder  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 43 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Murphree Co Mo. (City, town or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy 55e  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
11. Industry or business \_\_\_\_\_  
12. Name John J. Conrod  
13. Birthplace Murphy Mo. (City, town or county) (State or foreign country)  
14. Maiden name Mrs. Dick  
15. Birthplace Murphy Mo. (City, town or county) (State or foreign country)  
16. (a) Informant Merlin E. Sprock  
(b) Address House Springs R. 1  
17. (a) Burial (b) Date thereof Feb 9 1946 (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Rock Creek Cem  
18. (a) Signature of funeral director Louis H. Papp, Inc.  
(b) Address Kerwood Mo.  
19. (a) Feb 5 1946 (b) Mrs. J. H. Huebels (Date received by registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence Feb 5 1946  
(c) Where did injury occur? Right side Jefferson Mo. (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 Dr. Her Carrasco (M.D. or other) D.C.  
Address 3322 Greenwood Blvd. Date signed Feb 5 1946

**RECEIVED**  
District Health Officer No. 9,  
District File Number \_\_\_\_\_  
Date Filed 3-6-46

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**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..... *Felix Edmund*

Licensed Embalmer No..... *3034*

P. O. Address..... *Kirkwood 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ma  
 Registrar's No. 4

Registration District No. 141

Primary Registration District No. 5594

1. PLACE OF DEATH:  
 (a) County Jefferson  
 (b) City or town House Springs  
(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)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Jefferson  
 (c) City or town House Springs  
(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 Christiana 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 W  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Aug 23  
(Month) (Day) (Year)

8. AGE: Years 43 Months \_\_\_\_\_ Days \_\_\_\_\_ (Unless than one day)  
 hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_  
(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) Feb 5, 1946 (b) (Mrs. J. L. Huels)  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 2 Year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_  
 that I last saw him/her alive on \_\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

6224