

FILED OCT 1 1946
STANDARD CERTIFICATE OF DEATH

State File No. **29807**

Registration District No. **39**

Primary Registration District No. **4097**

Registrar's No. **141**

1. PLACE OF DEATH:

(a) County **Cass Co**
(b) City or town **Harrisonville**
(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 **6 years** (Specify whether years, months or days)
In this community **6 years**

3. (a) PRINT FULL NAME

Rella C. Spry

(b) If veteran, name war **✓**

(c) Social Security No. **✓**

4. Sex **MO** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **May Spry** 6. (c) Age of husband or wife if alive **57 years**
7. Birth date of deceased **10 - 21 - 1885**
(Month) (Day) (Year)

8. AGE: Years **61** Months **8** Days **5** If less than one day hr. min.

9. Birthplace **Herry Co Mo** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer merchant**

11. Industry or business

12. Name **George William Spry**

13. Birthplace **Haward Co Mo** (City, town, or county) (State or foreign country)

14. Maiden name **Therese Shipp**

15. Birthplace **Howard Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **Harold Spry**

(b) Address **Wich Mo**

17. (a) **Burial** (b) Date thereof **9-29-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wich Cem**

18. (a) Signature of funeral director **Fred Williams**

(b) Address **Clinton Mo**

19. (a) **9-27-46** (b) **Laura J. Jones**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Cass**
(c) City or town **Harrisonville Mo**
(If outside city or town limits, write "RURAL")
(d) Street No. **305 Main St** (If rural, give location)
(e) Citizen of foreign country? **✓** (Yes or No)
If yes, name country **✓**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **9** day **26**
year **1946** hour **8:30** minute **50 PM**

21. I hereby certify that I attended the deceased from **Sept 23**, 19**46**, to **Sept 26**, 19**46**; that I last saw h.c. in alive on **Sept 26**, 19**46**; and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion** Duration **1 wk.**

Due to **Coronary Disease**

Due to _____

Other conditions **diabetes**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy **61**

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 **Laura J. Jones** (Date or other)

Address _____ Date signed **9-27-46**

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

28643

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.

Signature

Licensed Embalmer No. *5478*

P. O. Address *Clinton M*

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.