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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 10

Primary Registration District No. 5036

Registrar's No. 135

1. PLACE OF DEATH:

(a) County Audrain

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

(c) Name of hospital or institution:
R. #1 Thompson
(If not in hospital of institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 60 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Audrain

(c) City or town Thompson Rural
(If outside city or town limits, write "RURAL")

(d) Street No. R. 1
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Lee Spurling

3. (b) If veteran, name war. No

3. (c) Social Security No. No

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Henry J Spurling

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

7. Birth date of deceased June 3, 1864
(Month) (Day) (Year)

8. AGE: Years 82 Months 4 Days 4
If less than one day _____ hr. _____ min.

9. Birthplace Calloway County, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Hudson

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

14. Maiden name Bohoman Sims

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

16. (a) Informant Russell Spurling

(b) Address Thompson, Mo.

17. (a) Burial (b) Date thereof 10/9/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Cemetery

18. (a) Signature of funeral director Cleaveland

(b) Address Mexico Mo

19. (a) 10/9/1946 (b) Blanche Neely
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 7
year 1946 hour 2 minute 35 P.M.

21. I hereby certify that I attended the deceased from Aug 1 to Oct 7, 1946
that I last saw her alive on 10-9- 1946
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis chr.
hypertension
due to nephritis chr.

Due to seuclity

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

Major findings:
Of operations _____
Of autopsy 124B

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 W. L. Williams (M. D. or other) M.D.
Address Mexico Mo Date signed 10/9/46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 10
District File Number 10-46-1901
Date Filed OCT 14 1946

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 *Chas. Arnold*

Licensed Embalmer No. *3569*

P. O. Address *Mexico, 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.