

FILED MAY 2 3 1947
Registration District No. _____

Primary Registration District No. **6269**

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

1. PLACE OF DEATH:
 (a) County **Webster**
 (b) City or town **Rural-Ozark Township**
(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 **x**
(Specify whether years, months or days)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME **Ella Jones Spink**
 3. (b) If veteran, name war **x**
 3. (c) Social Security No. **x**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **widowed**
 6. (b) Name of husband or wife **Frank P. Spink** 6. (c) Age of husband or wife if alive **x** years
 7. Birth date of deceased **January-11-1873**
(Month) (Day) (Year)

8. AGE: Years **24** Months **3** Days **13** If less than one day **x** hr. **x** min.

9. Birthplace **Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **Andrew W. Jones**

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

14. Maiden name **Sarah C. Whipkey**

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

16. (a) Informant **Lynton Spink (son)**

(b) Address **Marshfield, Mo.**

17. (a) **Removed** (b) Date thereof **4-26-47**
(Month) (Day) (Year)

(c) Place: burial or cremation **Pratt, Kansas.**

18. (a) Signature of funeral director **Rep. Rainey**

(b) Address **Marshfield, Missouri.**

19. (a) **4-28-47** (b) **J. Francis**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Webster** // 2
 (c) City or town **Rural** 0
(If outside city or town limits, write "RURAL")
 (d) Street No. **Ozark Township** 0
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No) 0
 If yes, name country **x**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **24**
 year **1947** hour **2** minute **30** AM.

21. I hereby certify that I attended the deceased from **June 8** 19**46**, to **April 24** 19**47**
 that I last saw her alive on **April 6** 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Heart Disease** **year**

Due to **Arteriosclerosis** **Several years**

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

Major findings: Of operations **AAA**
 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) (e) Means of injury

23. Signature **J.P. Macdonald** (M. D. or other) **M.D.**
 Address **Marshfield, Mo.** Date signed **4/24/47**

DEC 4 1947

RECEIVED

District Health Officer No. 6;

District File Number 447-512

Date Filed APR 29 1947

MAY 27 1947

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 _____

Licensed Embalmer No. 3312

P. O. Address Marshfield, 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.