

FILED OCT 17 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35038

Registration District No. 207

Primary Registration District No. 5756

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Maries
(b) City or town High Gate
(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 Lifetime
years, months or days

3. (a) PRINT FULL NAME Albert Kinsey Spurgeon

3. (b) If veteran, name war _____ * _____
3. (c) Social Security No. 499-03-798

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Carmoleta Harrison
6. (c) Age of husband or wife if alive 32 years
7. Birth date of deceased August 21 1905
(Month) (Day) (Year)

8. AGE: Years 42 Months 1 Days 7
If less than one day hr. _____ min. _____

9. Birthplace High Gate Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Assessor

11. Industry or business _____

12. Name John C. Spurgeon
13. Birthplace Jakes Prairie Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Eliza Bray
15. Birthplace Paydown Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Albert Spurgeon
(b) Address High Gate Missouri

17. (a) Burial (b) Date thereof 10-1-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation High Gate Baptist Cen.
Milford H. H. Winter

18. (a) Signature of funeral director Owensville, Mo.
(b) Address _____

19. (a) 10-5-47 (b) Pauline Howard
(Date received local registrar) (Registrar's signature) 1947

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Maries 63
(c) City or town High Gate 0
(If outside city or town limits, write "RURAL")
(d) Street No. _____ No. (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 28
year 1947 hour 2 minute _____ a. M.

21. I hereby certify that I attended the deceased from Sept. 10 1947 to Sept. 28 1947
that I last saw him alive on Sept. 28 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion 14 days
Due to Angina Pectoris 18 days

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

Major findings: Of operations 947
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) _____
While at work? _____ (e) Means of injury _____

Signature P. H. Schenck M. D. or other PP
Address Belle, Mo. Date signed 9/29/47

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District No. 100
Date Filed OCT 16 1947

NOV 18 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.....

Harvey Hall Registered Apprentice No. *9*
working under my personal supervision.

Signed *Michael A. Winter*

Licensed Embalmer No. *3138*

P. O. Address *Quincyville Md.*

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.