

No. 2  
5-43  
-17-30  
X-3677

FILED OCT 29 1947

Registration District No. 373 Primary Registration District No. 1122 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Scott County  
(b) City or town Illius mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: None In hospital or institution None  
In this community all life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri County Scott  
(c) City or town Illius mo 100  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural 0  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Wilhelmina Springer  
(b) If veteran, name war ✓  
(c) Social Security No. 4

4. Sex Female 5. Color or race W  
6. (a) Single, widowed, married, divorced 21  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec 1 1874  
(Month) (Day) (Year)

8. AGE: Years 72 Months 10 Days 11  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER

12. Name Henry Pritz 4  
13. Birthplace Berlin (City, town, or county) (State or foreign country)  
14. Maiden name Wilhelmina Pritz  
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Ben Springer  
(b) Address Illius mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14-47  
(Month) (Day) (Year)  
(c) Place: burial or cremation Illius mo

18. (a) Signature of funeral director W. G. Howell While at work? no (Specify type of place)  
(b) Address Cap. Richardson mo (c) Means of injury \_\_\_\_\_  
19. (a) 10-22-47 (Date received local registrar) (b) W. G. Howell (Registrar's signature) 200

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 17  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw her alive on 10 and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension  
Stroke  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy none

Duration

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 3  
(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? \_\_\_\_\_

23. Signature A. B. Lee (M. D. or other) M. D.  
Address Illius mo Date signed 10/16/47

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

RECEIVED

District Health Office No. 2,

File No. Number 1047-1382

Date issued 10-27-47

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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 W. H. Estes

Licensed Embalmer No. 3568

P. O. Address Cape Girardeau

**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. Nov  
Registrar's No. \_\_\_\_\_

Registration District No. 330

Primary Registration District No. 6/124

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Illmo  
(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 \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(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

Wilhelmud Sprunger

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 Wed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Dec 1  
(Month) (Day) (Year)

8. AGE: Years 72 Months \_\_\_\_\_ Days \_\_\_\_\_ If less 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) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY 2

36793