FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 20 1948

Registration District No. 385

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3039

State File No. 23508

Registrar's No. 179

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Marceline
(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 years, months or days)

In this community: 28 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Linn

(c) City or town: Marceline
(If outside city or town limits, write "RURAL")

(d) Street No.: W. Howe
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: James Peter Anspach

3. (b) If veteran, name war:

3. (c) Social Security No.: 486-12-7690

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Mg.

6. (b) Name of husband or wife: Anna Cora Anspach

6. (c) Age of husband or wife if alive: 64 years

7. Birth date of deceased: Jan 24 1883
(Month) (Day) (Year)

8. AGE: Years: 65 Months: 5 Days: 4 If less than one day: hr. min.

9. Birthplace: Bucklin (City, town, or county) Mo (State or foreign country)

10. Usual occupation: Laborer

11. Industry or business:

MOTHER FATHER

12. Name: Peter Anspach

13. Birthplace: Jamestown Ohio (City, town, or county) (State or foreign country)

14. Maiden name: Catherine McClain

15. Birthplace: Jamestown Ohio (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Earl White

(b) Address: Marceline Mo

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

(c) Place: burial or cremation: Mt Olivet

18. (a) Signature of funeral director: James M Laughlin

(b) Address: Marceline, Mo.

19. (a) June 30, 1948 (Date received local registrar) (b) Mary Jane Owens (Registrar's signature) 401

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from June 1, 1948 to June 29, 1948 that I last saw him alive on June 27, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	
c Myocardial infarction	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Robert W. [illegible] (M. D.)

Address: Marceline, MO Date signed: 6/30/48

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK

AUG 25 1948

NOV 6 1958

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Dale Bunch

Licensed Embalmer No. 4088

P. O. Address Marceline M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23508

Registration District No. 385 Primary Registration District No. 3039 Registrar's No. 179

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Marceline

(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 years, months or days)

In this community

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 James P. Arspach

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Anna Craig Arspach

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

7. Birth date of deceased Jan 24 1883 (Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 7 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) Mary Oneawe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month year 1948 hour minute M.

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

	Duration
Immediate cause of death	
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY