

FILED JUN 2 1949 THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15155
Registrar's No. 43

BIRTH NO.		REG. DIST. NO. 58		PRIMARY REG. DIST. NO. 3009		Registrar's No. 43			
1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Jackson</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural North Twp</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>209 Elm St</u>				d. STREET ADDRESS (If rural, give location) <u>3 miles South Gordonville Mo</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>WALTER</u> b. (Middle) <u>JOHN</u> c. (Last) <u>SPRINGER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>May 25, 1949</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Dec 16, 1918</u>			
9. AGE (In years last birthday) <u>30</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Gordonville Mo</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Henry Springer</u>		13b. MOTHER'S MAIDEN NAME <u>Minnie Amelunke</u>		14. NAME OF HUSBAND OR WIFE <u>Linda Hechig Springer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <u>Henry Springer Gordonville Mo</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Epilepsy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>4/201</u> <u>20 yrs. +</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? - YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Sept 10, 1948</u> , to <u>May 25, 1949</u> , that I last saw the deceased alive on <u>May 25, 1949</u> , and that death occurred at <u>3:45 Am.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>C. P. McDonald, M.D.</u>				23b. ADDRESS <u>Jackson, Mo.</u>		23c. DATE SIGNED <u>5-27-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 27-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>		24d. LOCATION (City, town, or county) (State) <u>Jackson Mo.</u>			
DATE REC'D BY LOCAL REG <u>May 28-49</u>		REGISTRAR'S SIGNATURE <u>D. G. Schubert</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Miller Jackson Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Miss. Dept. Health Officer No. 4
File Number 649-732
Date Filed 6-1-49

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Gene C. Crockett

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.