

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15987**

FILED MAY 28 1952

BIRTH NO. _____		REG. DIST. NO. 99		PRIMARY REG. DIST. NO. 4172		Registrar's No. 97	
1. PLACE OF DEATH a. COUNTY Dekalb				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dekalb			
b. CITY (If outside corporate limits, write RURAL and give town) STEWARTSVILLE		c. LENGTH OF STAY (in this place) 1320		c. CITY (If outside corporate limits, write RURAL and give township) Clarksdale			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location) 0			
3. NAME OF DECEASED (Type or Print)		a. (First) Nannie		b. (Middle) -----		c. (Last) Sprague	
4. DATE OF DEATH (Month) (Day) (Year) 5 14 52		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 4/10/1877		9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Covington, Ky.	
12. CITIZEN OF WHAT COUNTRY? 1		13a. FATHER'S NAME Perry Cunningham		13b. MOTHER'S MAIDEN NAME Laura Ann Brown		14. NAME OF HUSBAND OR WIFE Wm. E. Sprague	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Wm. E. Sprague, Clarksdale Mo.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Insufficiency 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.				INTERVAL BETWEEN ONSET AND DEATH 7 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4222				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.		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 4-5 19 52 , to 5-14 , 19 52 , that I last saw the deceased alive on 5-14 , 19 52 , and that death occurred at 3 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE E. J. Denny, M.D.				23b. ADDRESS Stewartsville, Mo.		23c. DATE SIGNED 5-15-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5/16/52		24c. NAME OF CEMETERY OR CREMATORY Independence		24d. LOCATION (City, town, or county) (State) No. of Hemple, Mo.	
DATE REC'D BY LOCAL REG. 6-22-52		REGISTRAR'S SIGNATURE Reserved		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W.E. Summerfield Stewartsville, Mo.			

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

1320

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *W.E. Summerfield*

Licensed Embalmer No. *3007*

P. O. Address *Stewartsville, 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.