

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

12972

State File No. _____

No. 300
10.48

FILED APR 7 1953

BIRTH NO. _____ REG. DIST. NO. 336 PRIMARY REG. DIST. NO. 6131 Registrar's No. 237

1. PLACE OF DEATH a. COUNTY <u>Shannon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Shannon</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mountain View, Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Mountain View, Mo</u>	
c. LENGTH OF STAY (In this place)		1010	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>None</u>		d. STREET ADDRESS (If rural, give location) <u>Rural</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>E. Spacek</u> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 17 1953</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced 3</u>	8. DATE OF BIRTH <u>Jan 5th 1870</u>	9. AGE (In years less birthday) <u>83</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Czechslovakia 6</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Not Known</u>	13b. MOTHER'S MAIDEN NAME <u>Not Known</u>	14. NAME OF HUSBAND OR WIFE <u>Marie SPACEK</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Otto Spacek</u> ADDRESS <u>Mountain View Mo</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>4201</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 Jan 15, 1953, to Feb 5, 1953, that I last saw the deceased alive on Feb 5, 1953, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) <u>Thomas R. Skaggs O M.D.</u>	23b. ADDRESS <u>Mtn View Mo</u>	23c. DATE SIGNED <u>Mar 5-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Feb 19 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mtn View Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Mountain View, Mo</u>
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DATE REC'D BY LOCAL REG. <u>Apr 6 53</u>	REGISTRAR'S SIGNATURE <u>Mabel Reel</u> <u>447</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Duncan Funeral Home</u> ADDRESS <u>Mtn View, Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

John L. Bureau
Licensed Embalmer No. *2516*
P. O. Address *2700 Ave. Mc*

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.