

FILED OCT 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29944

State File No.
Registrar's No. 500

BIRTH NO. REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Butler	
b. CITY (If outside corporate limits, write RURAL and give town or township) Poplar Bluff, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) Poplar Bluff	
d. FULL NAME OF HOSPITAL OR INSTITUTION Doctors Hosp.		d. STREET ADDRESS (If rural, give location) 650 Vine St.	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Spaulding c. (Last) Spaulding	4. DATE OF DEATH (Month) (Day) (Year) Sept. 16, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 3, 1881	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 10 Days 13	IF UNDER 2 WKS. Hours 13 Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY Eye, Ear, Nose, Throat	11. BIRTHPLACE (State or foreign country) Hartford, Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME John Spaulding	13b. MOTHER'S MAIDEN NAME Ella Leniver	14. NAME OF HUSBAND OR WIFE Edith Giërth Spaulding
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs. Spaulding	ADDRESS Poplar Bluff, Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		5 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Parkinsonian Syndrome		5 years
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 350 X	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Apr. 1849, to Sept. 16, 1954, that I last saw the deceased alive on Sept. 15, 1954, and that death occurred at 4:50 A.M., from the causes and on the date stated above.

23a. SIGNATURE F. L. Mueller M.D.	(Degree or title)	23b. ADDRESS Poplar Bluff Mo	23c. DATE SIGNED 9/27/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-18-54	24c. NAME OF CEMETERY OR CREMATORY City Cemetery	24d. LOCATION (City, town, or county) (State) Poplar Bluff, Mo.
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DATE REC'D BY LOCAL REG. 10/2/54	REGISTRAR'S SIGNATURE F. L. Mueller	48970	25. FUNERAL DIRECTOR'S SIGNATURE Frank-Cotrell	ADDRESS Poplar Bluff, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

OCT 4 - 1954

BUTLER CO. HEALTH CENTER

FILE No. _____

JAN 9 1955

OCT 7 1957

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 Wallace R Knight

Licensed Embalmer No. 437K

P. O. Address P.B.

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.