

FILED OCT 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31059**

BIRTH NO. _____ REG. DIST. NO. **157** PRIMARY REG. DIST. NO. **3028** Registrar's No. **197**

1. PLACE OF DEATH a. COUNTY Gasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY Gasper	
b. CITY (If outside corporate limits write RURAL and give township) Carthage MO	c. LENGTH OF STAY (in this place) 5 da	c. CITY OR TOWN Sarsawie MO	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION M-Cune Bros Hosp		e. STREET ADDRESS (If rural, give location) MO 0491	

3. NAME OF DECEASED (Type or Print) a. (First) Joseph J. b. (Middle) Sprague c. (Last) Sprague			4. DATE OF DEATH (Month) (Day) (Year) 9-26-54		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) unwedded	8. DATE OF BIRTH 9-17-1859		9. AGE (In years last birthday) 95 <input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> UNDER 1 HR. <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Retired photographer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Waukegan Ill		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME P. Sprague		13b. MOTHER'S MAIDEN NAME Elizabeth Haggard		14. NAME OF HUSBAND OR WIFE Jane 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. None		17. INFORMANT'S SIGNATURE OR NAME Eddie Sprague		ADDRESS Sarsawie 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) accidental injuries				INTERVAL BETWEEN ONSET AND DEATH 5 days	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Concussion					
		DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Serility				E9035 44	

19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Sarsawie Gasper MO	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 21 '54 6p.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Slipped and fell during rain storm	
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22. I hereby certify that I attended the deceased from **Sept 21, 1954**, to **Sept 26, 1954**, that I last saw the deceased alive on **Sept 26, 1954**, and that death occurred at **9:20 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE George H. Wood MD		23b. ADDRESS Carthage MO		23c. DATE SIGNED 9/28/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-28-54		24c. NAME OF CEMETERY OR CREMATORY Sarsawie Cem		24d. LOCATION (City, town, or county) (State) Sarsawie MO	
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DATE REC'D BY LOCAL REG. 9-28-54		REGISTRAR'S SIGNATURE W. Clinton		25. FUNERAL DIRECTOR'S SIGNATURE Jackson & Sons		ADDRESS Sarsawie MO	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATE OF MISSISSIPPI
 DEPARTMENT OF HEALTH
 BUREAU OF PUBLIC HEALTH
 BUREAU OF VITAL STATISTICS

RECEIVED OCT 6 1954
 Jasper County Health Office
 County File Number 54-10-836
 Date Filed OCT 6 1954

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. Me working under my personal supervision.

Student _____
 Signature of Student Embalmer

Signed Wm K Jackson
 Licensed Embalmer No. 395
 P. O. Address Savoy

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
 If this body is not embalmed, fact should be so stated above.