

No. 300
10.48

FILED JUL 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21623

BIRTH NO.		REG. DIST. NO. 84	PRIMARY REG. DIST. NO. 4147	Registrar's No. 15
1. PLACE OF DEATH a. COUNTY Cooper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Cooper		
b. CITY (If outside corporate limits enter RURAL and give township) OR TOWN Bunceston Sup	c. LENGTH OF STAY (in this place) 12 yrs	c. CITY OR TOWN Bunceston	d. Is Residence within limits of a city incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address of location) HOSPITAL OR INSTITUTION		e. STREET ADDRESS (If rural, give location) 0270		
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) FRED c. (Last) SPANGLER		4. DATE OF DEATH (Month) (Day) (Year) July 12, 1955		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married	8. DATE OF BIRTH Feb 9, 1879	9. AGE (In years, months, days, hours, min.) 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone worker	10b. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (City and State or Foreign Country) Pilot Grove, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME John Spangler	13b. MOTHER'S MAIDEN NAME Lula	14. NAME OF HUSBAND OR WIFE Sarah Spangler		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If so, no. or unknown) (If yes, give year or dates of service) no	16. SOCIAL SECURITY NO. 496-01-1193	17. INFORMANT'S SIGNATURE OR NAME Mrs Sarah Spangler, Bunceston, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMMORRHAGE ANTECEDENT CAUSES DUE TO (b) HYPERTENSION DUE TO (c) 331X II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 2 days
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		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)	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 7/10, 1955, to 7/10, 1955, that I last saw the deceased alive on 7/10, 1955, and that death occurred at 6:30 P.M., from the causes and on the date stated above.				
23a. SIGNATURE (Deceased or title) J. F. Potts M.D.		23b. ADDRESS Tipton, Mo.		23c. DATE SIGNED 7/13/55
24a. BURIAL / CREMATION / REMOVAL (Specify) Burial	24b. DATE July 14, 1955	24c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	24d. LOCATION (City, town, or county) (State) Bunceston, Mo	
DATE REC'D BY LOCAL REGISTRY July 14, 1955	REGISTRAR'S SIGNATURE Nellie Mullett 73	25. FUNERAL DIRECTOR'S SIGNATURE & ADDRESS Hays Painter Pilot Grove, Mo.		

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

12-1-75

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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.....
Signature of Student Embalmer

Signed.....
Raymond E. Hayes

Licensed Embalmer No. *307*

P. O. Address *Bellevue*

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.