

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37035

State File No. ....  
4283

FILED NOV 18 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

|   |                               |  |  |  |  |
|---|-------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>   |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b> |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <b>Kansas City</b>  |                               | c. LENGTH OF STAY (in this place)<br><b>34 YEARS</b>   | c. CITY OR TOWN <b>Kansas City</b>   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>General Hospital No. 1</b>   |                               |  | e. STREET ADDRESS (If rural, give location)<br><b>70 394 RORNOKE ROAD 3700</b>   |  |  |
| 3. NAME OF DECEASED (Type or Print)   | a. (First) <b>JENNIE</b>      | b. (Middle) <b>R.</b>  | c. (Last) <b>Spratt</b>  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>10 3 1955</b>                              |  |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>                                  | 8. DATE OF BIRTH <b>MAY 23, 1861</b>   | 9. AGE (In years last birthday) <b>94</b>  | IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>AT HOME</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>MODINA, MISSOURI</b>             | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |
| 13a. FATHER'S NAME <b>MICHAEL D. REYNOLDS</b>   |                               | 13b. MOTHER'S MAIDEN NAME <b>CHARITY V COCHRAN</b>   |  | 14. NAME OF HUSBAND OR WIFE <b>JOHN MARTIN SPRATT</b>                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                               | 16. SOCIAL SECURITY NO. <b>NONE</b>  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>MRS ELIZABETH S. SHELTERS. 394 RORNOKE</b>   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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  |  |  |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary congestion and edema</b>  |                               |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) <b>pulmonary abscess (m.m.o.)</b>   |                               |  |  |  |  |
| DUE TO (c) _____  |                               |  |  |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>Senility</b>  |                               |  | <b>521 X</b>   |  |  |
| 19a. DATE OF OPERATION  |                               | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |  |
| 21a. ACCIDENT (Specify)<br>SUICIDE<br>HOMICIDE  |                               | 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 <b>Sept. 20, 1955</b> , to <b>Oct. 3, 1955</b> , that I last saw the deceased <input checked="" type="checkbox"/> alive on <b>Oct. 3, 1955</b> , and that death occurred at <b>8:30P</b> m., from the causes and on the date stated above. |                               |  |  |  |  |
| 23a. SIGNATURE <b>B. I. Burns</b> (Degree or title) <b>M.D.</b>   |                               |  | 23b. ADDRESS <b>24th &amp; Cherry</b>  |  | 23c. DATE SIGNED <b>10-4-1955</b>  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>  |                               | 24b. DATE <b>OCT. 5, 1955</b>  | 24c. NAME OF GENEALOGY OR CREMATORY <b>D. W. NEWCOMER'S SONS</b>   | 24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>              |  |
| DATE REC'D BY LOCAL REG. <b>10-5-55</b>   |                               | REGISTRAR'S SIGNATURE <b>Mrs. Minnie J. Newcomer</b>   |  | 25 FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J. H. Newcomer's Sons, Kansas City, Mo.</b> |  |

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

STATE OF IOWA

EMBALMER

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..... *Robert E. ...*

Licensed Embalmer No. 48

P. O. Address..... *R. P. ...*

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.