

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS AUG 11 1959**

**59-027929**

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 127 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
a. COUNTY <u>Vernon</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Twp.</u>		a. STATE <u>Mo</u>		b. COUNTY <u>Camden</u>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>No, State Hosp. # 3 Nevada Mo.</u>		Length of stay in lb <u>6y4mo11d</u>		c. CITY OR TOWN <u>Edwards Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>none</u>		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Month Day Year		
First <u>Roseanna</u>		Middle <u>?</u>		Last <u>Spurling</u>		<u>8 1 1959</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/3/75</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Jerseyville Illinois</u>	Months <u>8</u> Days <u>24</u>	Hours	Min.	
12. CITIZEN/OF WHAT COUNTRY <u>USA</u>			13a. FATHER'S NAME <u>Patrick Fitzpatrick</u>		13b. MOTHER'S MAIDEN NAME <u>Marie Condon</u>		14. NAME OF HUSBAND OR WIFE <u>Clarence Spurling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Clarence Spurling (now deceased)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Arterio sclerotic Cardiovascular Disease</u>						<u>1 week</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b)		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chr. Brain Synd. assoc. with Senile Brain Dis.</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour <u>8:05</u> a.m. p.m.	Month, Day, Year <u>7/1/59</u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>7/1/59</u> to <u>8/1/59</u> and last saw her him alive on <u>8/1/59</u> . Death occurred at <u>8:05</u> <u>p</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>[Signature]</u>				22b. ADDRESS <u>Nevada Mo</u>		22c. DATE SIGNED <u>8/1/59</u>		
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-3-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>Nevada, Missouri</u>		(State)	
24. FUNERAL DIRECTOR ADDRESS <u>Wayne Funeral Service, Inc</u>			25. DATE RECD. BY LOCAL REG. <u>8-3-1959</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
(Licensed Embalmer's Statement on Reverse Side)								

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Richard L. Luffin

Licensed Embalmer No. 15053

P. O. Address Hart, K

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.