

FEDERAL BUREAU OF INVESTIGATION
FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 8 1959 38

59-038944

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 3006 Registrar's No. 596

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		c. CITY OR TOWN <u>Clarksuille</u>	
Length of stay in 1b _____		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Univ. of Mo. Med. Center</u>		d. STREET ADDRESS (If outside, give location) <u>General Delivery</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Spangler</u>			4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1959</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-59</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months _____ Days <u>1</u>	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Louisiana, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>United States</u>
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13a. FATHER'S NAME <u>Joseph Leon Spangler</u>	13b. MOTHER'S MAIDEN NAME <u>Helen Ilene Tobias</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Hospital Chart U.M.M.C.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Pulmonary Insufficiency</u>	
	DUE TO (c) <u>Prematurity</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>none</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 _____
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21. I attended the deceased from Nov 28, 1959 to Nov 29, 1959 and last saw her alive on Nov 29, 1959
 Death occurred at 6:40 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Roy August Waterfeld MD</u>	22b. ADDRESS <u>Univ. of Mo. Med Center Columbia Mo</u>	22c. DATE SIGNED <u>Nov 11/29/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) _____	23b. DATE <u>Nov 2 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	23d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Robert D. Johnston Columbia Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 2 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>
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(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 ^{not} _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.