

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-006052

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 101 Primary Registration District No. _____ Registrar's No. 7

FILED FEB 27 1962

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| 1. PLACE OF DEATH a. COUNTY <u>Douglas</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Douglas</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Benton Township</u> | | Length of stay in 1b <u>Life</u> | c. CITY OR TOWN <u>Ava</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Route 4,</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Annie Fae</u> Middle <u>Spring</u> Last _____ | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1962</u> |
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|-------------------------|----------------------------------|---|------------------------------------|-------------------------------------|--|--|
| 5. SEX <u>Female</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>1-31-47</u> | 9. AGE (last birthday) <u>15</u> | IF UNDER 1 YEAR Months _____ Days _____ | 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) <u>Child</u> | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Ava, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
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| 13a. FATHER'S NAME <u>Fred Spring</u> | 13b. MOTHER'S MAIDEN NAME <u>Nellie Nicholson</u> | 14. NAME OF HUSBAND OR WIFE |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Fred Spring, Ava, Mo. R. 4</u> | Address |
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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>Heart & Respiratory Failure</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>0</u> |
| DUE TO (b) <u>Brain-Tumor-Carcinoma Recurrent</u> | | <u>1 yr.</u> |
| DUE TO (c) <u>Paralysis</u> | | <u>6 mos.</u> |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Brain Operated - Columbia Mo.</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 _____, to _____ and last saw her/him alive on _____.
Death occurred at 11:30 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>[Signature]</i> | (Degree or title) | 22b. ADDRESS <u>Ava, Missouri</u> | 22c. DATE SIGNED <u>Feb 16 1962</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>2-20-62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fannon</u> | 23d. LOCATION (City, town, or county) (State) <u>Ava, Missouri</u> |
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| 24. FUNERAL DIRECTOR <u>Clinkingbeard Funeral Home, Ava, Mo.</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>2-17-62</u> | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles R. Fish

Licensed Embalmer No. 4662

P. O. Address Avon Mo.

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.