

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-041223

STATE FILE NUMBER

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 58

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 13 1962

VS 300
Rev. 4/59

1 0950
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>STE GENEVIEVE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>STE GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE GENEVIEVE</u>		Length of stay in 1b <u>1 DAY</u>	c. CITY OR TOWN <u>OZORA</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 <u>STE GENEVIEVE NURSING HOME</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ST. MARYS STAR RT.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN FRANK SPRAWL</u>			4. DATE OF DEATH Month Day Year <u>Nov - 6, 1962</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/1900</u>
9. AGE (last birthday) <u>62</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>	11. BIRTHPLACE (City and state or country) <u>STE GENEVIEVE CO. MO</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Joseph Sprawl</u>	
13b. MOTHER'S MAIDEN NAME <u>EMMA HAGAN</u>		14. NAME OF HUSBAND OR WIFE <u>Sophie Eichenlaub</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>Clatus Joseph Ozora, Mo</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ESOPHAGEAL (EXTRATHORACIC) STRICTURE 2 WKS</u>			
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>Senile Arteriosclerosis</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 Month, Day, Year a.m. p.m.			
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>11-5-62</u> to <u>11-6-62</u> and last saw ^{her} him alive on <u>11-5-62</u> Death occurred at <u>8:00 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Ste Genevieve Mo</u>	22c. DATE SIGNED <u>11-6-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11/8/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>	23d. LOCATION (City, town, or county) (State) <u>OZORA, MISSOURI</u>
24. FUNERAL DIRECTOR <u>BASLER FUNERAL HOME</u> ADDRESS <u>STE GENEVIEVE, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>7 November 1962</u>	26. REGISTRAR'S SIGNATURE <u>George F. Wood</u>

(Licensed Embalmer's Statement on Reverse Side)

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

Adrian J. Eiler

Licensed Embalmer No. 4740

P. O. Address

St. Jenerveiro 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.