

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

31335

State File No.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3433

1. PLACE OF DEATH:

(a) County Jackson 1
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 6 Weeks
years, months or days

3. (a) PRINT FULL NAME Mrs Josephine Spurgeon

3. (b) If veteran, name war PRO 3. (c) Social Security No. PRO

4. Sex Fr 5. Color or race wh 6. (a) Single, widowed, married, divorced, widow

6. (b) Name of husband or wife unkn 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased April 22 1884
(Month) (Day) (Year)

8. AGE: Years 55 Months 4 Days 9 If less than one day hr. ✓ min.

9. Birthplace Ill
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business ✓

12. Name Jerry M Sullivan 5

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Catherine Joyce

15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Geo Farrell

(b) Address 3733 Balt Ave

17. (a) removal (b) Date thereof 9-1-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bloomington Ill

18. (a) Signature of funeral director W. F. Whyberry

(b) Address Kansas City Mo

19. (a) 9-1-39 (b) mmmlarou
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill (b) County 2
(c) City or town Bloomington
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ✓ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 1
year 1939 hour 2 minute 35 M.

21. I hereby certify that I attended the deceased from July 15, 1939, to Sept 1, 1939
that I last saw h. ev alive on 9-1 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to Cerebral & pulmonary edema

Due to Hypertension III

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy Cerebral & pulmonary edema

PHYSICIAN _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Vincent Williams (M. D. or other) _____
Address _____ Date signed _____

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 _____

R. E. Snow

Registered ^{*Emb*} ~~Apprentice~~ No. *2560*

working under my personal supervision.

Signed _____

W. S. Mayberry

Licensed Embalmer No. *2934*

P. O. Address *R. O. 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 this body is not embalmed, above space should be left blank.