

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3603

Registration District No. 775

Primary Registration District No. 6070 A

Registrar's No. 14

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")
(d) Street No. West School St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ✓ years.

3. (a) PRINT FULL NAME

Mr. Sylvester Omar Spring

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Anna Spring

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January (Month)

30 (Day) 1850 (Year)

8. AGE: Years 89 Months 11 Days 27 If less than one day _____ hr. _____ min.

9. Birthplace Near Beardstown, Illinois (City, town, or county) (State or foreign country)

10. Usual occupation Retired Real Estate Dealer

11. Industry or business _____

12. Name Unknown Joseph Spring

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

14. Maiden name Hanna Fisk

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

16. (a) Informant's own signature Mr. Sam Long

(b) Address Bonne Terre, Mo.

17. (a) Burial (b) Date thereof Jan. 31, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Beardstown, Ill.

18. (a) Signature of funeral director Alvin W. Hawk

(b) Address Flax River, Mo.

19. (a) Jan 29, 1940 (b) N. W. Hawkins (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan, day 27, year 1940 hour 10 a.m. minute ✓ M.

21. I hereby certify that I attended the deceased from Jan. 26, 1940, to Jan. 26, 1940, that I last saw him alive on Jan. 26, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Cessation of function of vital forces of liver & lungs Duration 2 days
Old age

Due to Wasn't sick

Due to 16 2

Other conditions None (Include pregnancy within 3 months of death)

Major findings: Of operations No operation

Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 T. H. Son (M. D. or other)
Address Bonne Terre, Mo. Date signed 1/29/40

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.

I 19351

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address Flat River, 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.