

FILED MAR 7 - 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

## 1. PLACE OF DEATH

County CarrollRegistration District No. 137

Township

Primary Registration District No. 4077

City

Hale

(No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

File No. \_\_\_\_\_

6226

Registered No. 7

## 2. FULL NAME

(a) Residence, No. \_\_\_\_\_

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

/St. \_\_\_\_\_

Ward \_\_\_\_\_

(If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White5. SINGLE, MARRIED, WIDOWED, OR  
DIVORCED (write the word)Single5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF  
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

April-20-1885

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1  
day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.84927

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as spinner,  
sawyer, bookkeeper, etc.Housekeeper9. Industry or business in which  
work was done, as silk mill,  
saw mill, bank, etc.10. Date deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (CITY OR TOWN)  
(STATE OR COUNTRY)BristolTenn.

FATHER

13. NAME

Elkanah Spurgeon14. BIRTHPLACE (CITY OR TOWN)  
(STATE OR COUNTRY)Tenna.

MOTHER

15. MAIDEN NAME

Mary Schetter16. BIRTHPLACE (CITY OR TOWN)  
(STATE OR COUNTRY)Tenn.

17. INFORMANT

(ADDRESS)

Mrs. P. H. W. King  
Hale Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Hale Cemetery

DATE

Feb-18

1940

19. UNDERTAKER

(ADDRESS)

FRANK E. SLATOR  
Hale Mo.

20. FILED

Feb 181940

Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

Feb-17, 1940

22. I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1938, to Feb 17, 1940I last saw her alive on Feb 17, 1940. Death is saidto have occurred on the date stated above, at 5-2 m.

The principal cause of death and related causes of importance were as follows:

ArteriosclerosisDate of onset  
about 1935

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) W. P. Kerrick, M. D.

132 (Address)

Hale Mo

Mrs. Ruby Baues

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.

RECEIVED  
District Health Officer No. 8,  
Number 3/6/40

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. **6226**

Registration District No. **137**

Primary Registration District No. **4077**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Carroll**  
(b) City or town **Hale**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(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)

3. (a) PRESENT FULL NAME

**Sarah Frances Spruigen**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **F**

5. Color or race **W**

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

**84**

**9**

**27**

h. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_

(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_

(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. **Feb. 18, 1940** (b) **W. P. Kemp**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Carroll**

(c) City or town **Hale**  
(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 **Feb** day **17**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 5 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 **W. P. Kemp** (M. D. or other) \_\_\_\_\_

Address **Hale** Date signed \_\_\_\_\_

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

SUPPLEMENTAL COPY

