

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

7964  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Clair Registration District No. 761  
 (b) Township Appleton Primary Registration District No. 4456 Registered No. 9  
 or City Appleton City, Mo. (d) Street No. Ellett Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Fred J. Spilker  
 (a) Residence, No. 4504 Arsenal St.  St. Louis Mo.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dorla C. Spilker

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 13 - 1885

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hra. or .....min.
<u>55</u>	<u>1</u>	<u>9</u>	

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Traveling  
 9. Industry or business in which work was done, as saw mill, bank, etc. Salomons  
 10. Date deceased last worked at this occupation (month and year) Feb 22nd 11. Total time (years) spent in this occupation. 30 yrs

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Helboro Missouri

FATHER  
 13. NAME A. H. August  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis Mo.

MOTHER  
 15. MAIDEN NAME Emma Renna  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marionport Iowa

17. INFORMANT (ADDRESS) 6

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE removal DATE Feb 23 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Oscar Zechhoff  
Appleton city Mo.

20. FILED Feb 23 1940 Chas. Abney  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) February 22 1940

22. I HEREBY CERTIFY, That I attended deceased from February 22 1940 to February 22 1940, 1940.  
 I last saw him alive on February 22 1940 Death is said to have occurred on the date stated above, at 7:45 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Cerebral hemorrhage

Date of onset	<u>Feb. 22 1940</u>
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Other contributory causes of importance: g.H.P.

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) H. N. Boverman M. D.  
Appleton City, Mo. (Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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

1 X16005

JUN 25 1948

JUN 26 1948

RECEIVED  
District Health Officer No. 7,  
District File Number 3-40-324  
Date Filed 3-4-40

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 Osmer Eckhoff  
Licensed Embalmer No. 3942  
P. O. Address Appleton City

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 7964

Registration District No. 261

Primary Registration District No. 4456

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

1. PLACE OF DEATH

(a) County... St. Charles

(b) City or town... Appleton City  
(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) PRINT FULL NAME Fred J. Spilker

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.

55 1 9 \_\_\_\_\_ min.

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

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

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

12. Name August Spilker

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

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

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

16. (a) Informant Garfa J. Spilker

(b) Address St. Louis Mo.

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

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

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

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

19. (a) Feb. 23. 40 (b) Oles Abrey (Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (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.

20. DATE OF DEATH month Feb day 20 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

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

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

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

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

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

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 H. H. Boyer other \_\_\_\_\_

Address Appleton City Mo Date signed \_\_\_\_\_

IMPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

