

FILED AUG 23 1940

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

26476
Do not use this space.

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. PLACE OF DEATH

(a) County Shoemaker Registration District No. 834

(b) Township Pike Primary Registration District No. 6097

(c) City 0 (d) Street No. _____ 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 Ray Dean Spare

(a) Residence, No. _____ St. _____ (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9/16/1939

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

— 9 27

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Parson Mo

FATHER

13. NAME Eugene Spare

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Madison Mo

MOTHER

15. MAIDEN NAME Selia Kneese

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bill City Mo

17. INFORMANT (ADDRESS) Eugene Spare Parson Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Mount Zion DATE 7/14/40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Wm. J. ... Parson Mo.

20. FILED Aug 7 1940 D S McAlle 7 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/13 1940

22. I HEREBY CERTIFY, That I attended deceased from 7/10 1940 to 7/13 1940

I have been alive on 7/13 1940 Death is said to have occurred on the date stated above, at 10p m.

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

Hooping cough

Date of onset 6-1-40

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) J. A. Clive M. D.

(Address) Oran Mo

RECEIVED

District Health Officer No. 2,

District File Number 840-134

Date Filed 8/12/40

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.....

Licensed Embalmer No.....

P. O. Address.....

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.