

No. 2
13-40
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X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29651

Registration District No. 284

Primary Registration District No. 200

Registrar's No. 1541

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Overland
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Diestelkamp Home 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William J. Spurgin 162

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Nettie

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Dec. 24 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>73</u>	<u>7</u>	<u>18</u>	hr. _____ min.

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

10. Usual occupation Elaborer

11. Industry or business _____

12. Name Edmond Spurgin

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

14. Maiden name Ellen Gorman

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

16. (a) Informant Herman E. Spurgin

(b) Address 6537 Avalon Ave.

17. (a) Removal (b) Date thereof 8-13-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. James, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Ave.

19. (a) AUG 13 1940 (b) DR. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town University City
(If outside city or town limits, write "RURAL")

(d) Street No. 6520 Crest Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 12
year 40 hour 10 minute 4 M.

21. I hereby certify that I attended the deceased from Apr 17-1940
to Aug 12 1940

that I last saw him alive on Aug 2 1940
and that death occurred on the date and hour stated above.

Immediate cause of death "Heart Failure"
death immediate

Due to Chc. Myocarditis years

Other conditions Ex. Neck Hernia
(Include pregnancy within 3 months of death)

Major findings: Mar-20-40

Of operations _____

Of autopsy _____

Duration _____

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? Former Home
(City or town) (County) (State)

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

While at work _____ (e) Means of injury _____

23. Signature W. F. L... (M. D. or other) _____

Address 6204 W. F. L... Date signed Aug 12 1940

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

194B
99

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 *J. B. Sullivan*
Licensed Embalmer No. *1122*

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, fact should be so stated above.

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STANDARD CERTIFICATE OF DEATH

State File No. **29651**
Registrar's No. **1541**

Registration District No. Primary Registration District No.

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Overland
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Wm J. Ferguson
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 _____ year

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

8. AGE: Years Months Days .If less than one day hr. 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 973-40 (b) (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.

19. MEDICAL CERTIFICATION
20. DATE OF DEATH Month Aug Day 12 Year 40
hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____;
that I last saw him _____ alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure
Chr. Myocarditis

Due to _____
Due to Fract. neck humerus
3-20-40

Other conditions (Include pregnancy within 6 months of death)

Major findings: Of operations 6/6/10
Of autopsy Patient fell down stairs

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) Accident - Fall
(b) Date of occurrence 3-20-40
(c) Where did injury occur? Home - 6570 Crest
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
FOR RAKER H.D.M.E.
(Specify type of place) (e) Means of injury

23. Signature R. J. Schmidt (M. D. or other)
Address 6704 W. 11th Date signed _____

SUPPLEMENTARY

