

No. 2
-1-4-41
5-17-39
PI X26390

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 13 1941

Registration District No. 299

Primary Registration District No. 1002

State File No. 34042
Registrar's No. 3982

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

48
3
8

1. PLACE OF DEATH: Jackson
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: 1710 Park
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 20 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Frank Thomas Spriggs
3. (b) If veteran, None name war
3. (c) Social Security No. None
4. Sex Male
5. Color or race Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Anna Spriggs
6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased September 26, 1877
(Month) (Day) (Year)

8. AGE: Years 64 Months Days 26 If less than one day hr. min.

9. Birthplace New Market Md. (City, town, or county) (State or foreign country)
10. Usual occupation Janitor

11. Industry or business Unknown
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Virginia
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Anna Spriggs
(b) Address 1710 Park
17. (a) burial (b) Date thereof 10/25/41 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Highland Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address 1729 Lydia
19. (a) 10/25/41 (Date received local registrar) (b) M. H. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson 048
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 1710 Park Avenue (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct. day 22 year 1941 hour 10 minute 40 A.M.
21. I hereby certify that I attended the deceased from July 15 1941 to Oct 22 1941 that I last saw him alive on eve of Oct 21 1941 and that death occurred on the date and hour stated above

Immediate cause of death Coronary dilatation due to Myocardial degeneration Arteriosclerosis Other conditions Glomerular nephritis (Include pregnancy within 3 months of death)

PHYSICIAN
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 M. A. Eldem (M.D. or other) Address 3306 Woodland Ave Date signed 10/25/41

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..... *I. J. Manlove*.....
Licensed Embalmer No. *3994*.....
P. O. Address. *2573 Highland*.....

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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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. **3982**

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1710 Park
(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 **Frank Thomas Spriggs**

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

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

MOTHER FATHER { 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..... (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation.....

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

(b) Address **10/25/41** **Dr. J. C. Crome**

19. (a)..... (b)..... (Date 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **22**
year **1941** 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
Cardiac dilatation
Due to **myocardial degeneration**
arterio sclerosis
Other conditions **acute Glomerular glomerular nephritis**
(Include pregnancy within 3 months of death)

Major findings:
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?..... (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 **M. A. Epstein** (M. D. or other) **11/2/41**
Address **3306 Woodland Ave** Date signed.....

34042