

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

FILED JUL 14 1942

Registration District No. 83

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan  
 (b) City or town St. Joseph  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Joseph Hosp  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 6 Weeks  
 In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan  
 (c) City or town St. Joseph  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 2209 Francis St.  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1  
 year 1942 hour 7 minute 3 A. M.

21. I hereby certify that I attended the deceased from Apr 17 1942 to May 31 1942  
 that I last saw him alive on May 31 1942  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Labor puerperal (stroke) Duration 3/16/42  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions: Plurisy with effusion 4/1/42  
 (Include pregnancy within 3 months of death) not 15 days 4/6/42  
Cerebrosis of liver - occlus- PHYSICIAN

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Clarence M. Sprengel

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

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

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 8 1902  
 (Month) (Day) (Year)

8. AGE: Years 39 Months 10 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Salesman

11. Industry or business Shaw & Burton Adv.

12. Name John J. Sprengel

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

14. Maiden name Minnie Lynn

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

16. (a) Informant Mrs Minnie Springel  
 (b) Address 2209 Francis

17. (a) Burial (b) Date thereof June 3 42  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Cleve  
 (d) Signature of funeral director Fleeman & Son Inc.  
 (e) Address St. Joseph Missouri

19. (a) 6-2-42 (b) \_\_\_\_\_  
 (Date received local registrar) (Registrar's signature)

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 Frank H. Hagan (M. D. or other) \_\_\_\_\_  
 Address 620 Francis Date signed 6/1/42

*Hertig  
Kemp*

**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.....

.....  
working under my personal supervision.

....., Registered Apprentice No.....

Signed.....  
*Robert H. Hoyer*

Licensed Embalmer No. *3308*

P. O. Address *St Joseph, Mo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 20745  
Registrar's No. \_\_\_\_\_

Registration District No. 85

Primary Registration District No. 1001

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

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Clarence M. Sprengel

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 S

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

7. Birth date of deceased July 8 1942  
(Month) (Day) (Year)

8. AGE: Years 39 Months 10 Days 13 If less than one day \_\_\_\_\_ 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) 6-2-42 (b) Rae Heigog  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day \_\_\_\_\_  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_, 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 \_\_\_\_\_  
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. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

S-20745

NOV 24 1942