

No. 2  
5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

Dr. R. Williams

State File No. 42336

FILED JAN 11 1944  
Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1086

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Johns Hosp.  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution 3 Days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Marie Spannberger

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

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

6. (b) Name of husband or wife Joseph Spannderger 6. (c) Age of husband or wife if alive unk. years

7. Birth date of deceased Sept. 17 1879  
(Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 12 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Matthew Andrixs

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

14. Maiden name Unknown

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

16. (a) Informant Joseph Spannberger

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Dec. 31, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary

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

(b) Address Springfield, Mo.

19. (a) 12-31-43 (b) S. W. Hardy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1611 W. Lee  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) 0  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29  
year 1943 hour 10 minute 50 P.M.

21. I hereby certify that I attended the deceased from Dec 23, 1943 to Dec 29 - 1943  
that I last saw er alive on Dec 29, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 6 days

Due to

Due to

Other conditions ✓  
(Include pregnancy within 3 months of death)

Major findings: ✓  
Of operations

Of autopsy

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) no  
(b) Date of occurrence  
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) (c) Means of injury

23. Signature Robert J. Williams (M.D. or other)  
Address Springfield Mo Date signed 12-31-43

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

21

AUG 7 194

**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 *L. Doolin Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield Mo*

**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.**