

FILED APR 10 1944

Registration District No. 253

Primary Registration District No. 6196

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Current Top Rural
(c) Name of hospital or institution: 1
(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 Allen Gibson Spurgeon

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, married

6. (b) Name of husband or wife Georgia Spurgeon 6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased July 17 1869
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 15 If less than one day _____ hr. _____ min.

9. Birthplace Highgate, Md
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name James Spurgeon

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

14. Maiden name Nancy Blewett

15. Birthplace not known
(City, town, or county) (State or foreign country)

16. (a) Informant W.B. Spurgeon

(b) Address _____

17. (a) Burial (b) Date thereof 4-5-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Beverly Cem. Harmond Co.

18. (a) Signature of funeral director Smith & Ferguson

(b) Address _____

19. (a) 4/6 1944 (b) Walter Wilson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County Texas
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 3 Mi SW of Montauk MD
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 1944
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from SEPT. 1943 to DATE 19____;
that I last saw him alive on APRIL 1 1944
and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY OCCLUSION
Due to SENILITY

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

Major findings: Of operations 94a
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 L. M. Dillman (M. D. or other) M.D.
Address Houston, TX Date signed 4-5-44

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No: 5,

District File Number: 444229

Date Filed 4-8-44

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 Robert E. Ferguson

Licensed Embalmer No. 3945

P. O. Address Licking, 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, above space should be left blank.

FILED JUN 6 1944

Registration District No. 355

Primary Registration District No. 6203

Registrar's No.

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Current Sup Rural
(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 years, months or days)

3. (a) PRINT FULL NAME Allen H. Spurgeon

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 George 6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased July 17 1880
(Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 11 less than one day min.

9. Birthplace Highgate Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

12. Name James Spurgeon

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

14. Maiden name Nancy Blewens

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

16. (a) Informant W.B. Spurgeon
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof 4-5-44
(Month) (Day) (Year)

(c) Place: burial or cremation Bowen Cem. - Harrison Co. Mo.

18. (a) Signature of funeral director South Ferguson
(b) Address Sicking Mo
19. (a) April 15 '44 (b) Mrs. Paul Rice
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas
(c) City or town Rural
(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 April 1944 hour minute M.

21. I hereby certify that I attended the deceased from that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to senility

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 94d

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?

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

While at work? (Specify type of place) Means of injury

23. Signature L.M. Dillman (M. D. or other) MO

Address Houston, Mo Date signed

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

TEMPORARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District : _____ Officer No. 5,

District File Number _____

Date Filed _____