

FILED AUG 9 1944

State File No.

Registration District No. 171

Primary Registration District No. 5-639

Registrar's No. 33

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Mayvies Road
(c) Name of hospital or institution: Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 50 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Lafayette
(c) City or town Mayvies, Rural 54
(If outside city or town limits, write "RURAL") 0
(d) Street No. (If rural, give location) 9
(e) Citizen of foreign country? (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME August Herman Sprick
3. (b) If veteran, name war 3. (c) Social Security No. 1
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Sophia 6. (c) Age of husband or wife if alive 83 years
7. Birth date of deceased: Dec 16 1860
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 22 year 1944 hour 7 minute A. M.
21. I hereby certify that I attended the deceased from Jan 1943 to July 22 1944 that I last saw him alive on July 21 1944 and that death occurred on the date and hour stated above.

8. AGE: Years 83 Months 7 Days 7 If less than one day hr. min.
9. Birthplace Warren Co. Mo. (City, town, or county) (State or foreign country)

Immediate cause of death Nephritis
Duration
Due to.....
Due to.....
Other conditions none
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

10. Usual occupation Farmer
11. Industry or business
12. Name No Record
13. Birthplace Germany (City, town, or county) (State or foreign country)
14. Maiden name Horner
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. John Sprick
(b) Address Mayvies Mo. Rural
17. (a) Burial (b) Date thereof 7-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Evng. Cemetery, Higginsville Mo
18. (a) Signature of funeral director: Miss [Signature]
(b) Address Higginsville Mo
19. (a) July 26 1944 (b) Mrs. W. Baker
(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 Jno B Willis (M. D. or other)
Address Mayvies Mo Date signed 7/24/44

MOTHER FATHER

RECEIVED

District Health Officer No. 0,

District File Number

Date Filed 8-8-47

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

Roy F. Wiegner

Licensed Embalmer No. 2883

P. O. Address Higginsville

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.

Registration District No. 171

Primary Registration District No. 5639

Registrar's No. 23

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Rural Washington Twp
(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

August H Sprick

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 in

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

7. Birth date of deceased Nov 16 1866
(Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____ If less than one day _____ min.

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

MOTHER FATHER

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) (State or foreign country)

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) _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 2 year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____

that I last saw him alive on _____ and that death occurred on the date and hour stated above. Immediate cause of death pericarditis chronic

Duration

3 yrs.

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) _____

(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 John Bellville (M. D. or other) _____

Address Maywood, Mo. Date signed _____

SUPPLEMENTAL

MEDICAL BACK 2

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

930

26

251 (RE)

25041