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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42056

State File No. _____

FILED JAN 11 1946

Registration District No. 270

Primary Registration District No. 3050

Registrar's No. 100

1. PLACE OF DEATH:

(a) County Peru
(b) City or town Cauthersville
(If outside city or town limits, write "RURAL" and name of township)
(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 10 months years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Peru
(c) City or town Cauthersville
(If outside city or town limits, write "RURAL")
(d) Street No. 505 Eastwood ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Clement Spalding
(b) If veteran, name war ✓
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 25th
year 1945 hour 2 minute 40 A M.
21. I hereby certify that I attended the deceased from 12-25-1945 to 12-25-1945
that I last saw h. IM alive on 12-25 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced single
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased Dec 7 1927
(Month) (Day) (Year)

Immediate cause of death Thrustic injury to chest
Duration ✓
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years 18 Months 18 Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Cauthersville MO
(City, town, or county) (State or foreign country)

10. Usual occupation port man

11. Industry or business _____

MOTHER FATHER

12. Name Paul Spalding

13. Birthplace St. Louis MO
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Thompson

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

16. (a) Informant Paul Spalding

(b) Address Cauthersville MO

17. (a) Burial (b) Date thereof 12-28-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Miami Cemetery

18. (a) Signature of funeral director La. Faye and Co.

(b) Address Cauthersville MO

19. (a) 1-3-46 (b) Bessie B. Wilks
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____
Of autopsy _____
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 P. J. ... (M. D. or other) _____
Address Cauthersville MO Date signed 1-24-46

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

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

1485

12-45-236

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 Neel C. Deav

Licensed Embalmer No. 3941

P. O. Address Carruthersville, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JanRegistration District No. 240Primary Registration District No. 3050Registrar's No. 100

1. PLACE OF DEATH:

- (a) County Peoria
 (b) City or town Canthessville
 (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 Robert C. Spalding3. (b) If veteran,
name war.....3. (c) Social Security
No.....4. Sex M 5. Color or race W 6. (a) Single, widowed, married,
divorced S6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if
alive..... years7. Birth date of deceased Dec 7, 1927
(Month) (Day) (Year)8. AGE: Years 18 Months Days In 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) (Burial, cremation, or removal) (b) Date thereof.....
(Month) (Day) (Year)

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

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

(b) Address.....

19. (a) (Date received local registrar) (b) (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..... day.....
year..... hour..... minute..... M.21. I hereby certify that I attended the deceased from.....
19..... to..... 19.....that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....Due to Internal Hemorrhage
Punctured lung - from
broken rib.
Due to.....Other conditions.....
(Include pregnancy within 3 months of death)Major findings:
Of operations.....Of autopsy.....
1906-8-21

22. If death was due to external causes, fill in the following:

- (a) - Accident, suicide, or homicide (specify) Accident
 (b) Date of occurrence 12-25-45
 (c) Where did injury occur? Canthessville, Peoria, Mo.
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway 84 - between Canthessville & Peoria, Mo.
 (Specify type of place)
 While at work no (e) Means of injury Hit by auto

23. Signature P. J. Quinn, M.D. (M. D. or other).....Address Canthessville, Mo. Date signed 1-14-46

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline
the cause to
which death
should be
charged statistically.

42056