

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X365

State File No.

Registrar's No.

FILED MAY 22 1946
Registration District No. 156

Primary Registration District No. 2001

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

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Freeman Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 37 years.

3. (a) PRINT FULL NAME Rose A. Spaid

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 Widow

6. (b) Name of husband or wife Charles L. Spaid.

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

7. Birth date of deceased Aug. 1, 1869.
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>76</u>		<u>8</u>	<u>1</u>	hr. <u> </u> min. <u> </u>

9. Birthplace Macon Ill;
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business

12. Name Joseph J. Frick

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

14. Maiden name Ellen Wilkinson

15. Birthplace no record
(City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address 1905 Sargeant, Joplin Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Apr. 4 46
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Hope Cem.

18. (a) Signature of funeral director Hurlbut Und. Co.

(b) Address Joplin Mo.

19. (a) 4-4-46
(Date received local registrar)

(b) [Signature]
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

(c) City or town Joplin
(If outside city or town limits, write "RURAL")

(d) Street No. 1905 Sargeant Ave. Joplin Mo.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 2, day 1946
year hour 3-05 P.M. minute M.

21. I hereby certify that I attended the deceased from 19 to 19 ;
that I last saw h alive on 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetes Mellitus 13 1/2
Chronic Dehydrated Feet 13 1/2

Other conditions
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations

Of autopsy

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?

23. Signature [Signature] (M. D. or other)

Address 708 [Address] Date signed 4-4-46

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(Licensed Embalmer's Statement on Reverse Side)

Joplin Mo

46-4-353

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

William M. Lungy

Licensed Embalmer No. *3566*

P. O. Address *212 Poplin St.*

Worcester, Massachusetts

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.