

U. S. No. 2
 FORM-5-43
 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED SEP 8 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26901**
 Registrar's No. **1037**

Registration District No. **42** Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County Boonville, Mo.
 (b) City or town Boonville, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: M.O.M.E.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 23 days
 (Specify whether in hospital or institution)
 In this community 23 days
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County DeKalb 32
 (c) City or town King City, Mo. RR.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1
 (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME SARAH FRANCIS SPIKING
Sarah of road, Boonville
 3. (b) If veteran, name war NO 3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 1st
 year 1947 hour 8 minute 10 P.M.
 21. I hereby certify that I attended the deceased from 8-10-47
 _____, 19____ to 9-1-, 1947
 that I last saw her alive on 9-1-, 1947
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race cau - 6. (a) Single, widowed, married, divorced widow
 6. (b) Name of husband or wife John H. Spiking 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept 9, 1850
 (Month) (Day) (Year)

Immediate cause of death Pulmonary edema Duration 2 wks
 Due to Fractured hip 3 wks
 Due to Fall

Other conditions _____ (Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy _____

8. AGE: Years 96 Months 16 Days 22 If less than one day _____ hr. _____ min.
 9. Birthplace DeKalb Co. (City, town, or county) Mo. (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
186 A
13

10. Usual occupation Housework
 11. Industry or business None

MOTHER FATHER

12. Name Emuel Harvey
 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 14. Maiden name Wendell
 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 16. (a) Informant John H. Spiking
 (b) Address King City, Mo. RR.
 17. (a) (Burial, cremation, or removal) Mayville Mo (b) Date thereof 9-1-1947
 (Month) (Day) (Year)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director R. G. Taggart
 (b) Address King City, Mo.
 19. (a) 9-2-47 (b) G. B. Jenkins
 (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) accident 32
 (b) Date of occurrence 8-10-47
 (c) Where did injury occur? King City, Mo.
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home
 While at work? _____ (Specify type of place)
 (c) Means of injury Fall
 23. Signature Paul J. Jurganz (M. D. or other) _____
 Address St. Joseph, Mo. Date signed 9-1-47

NOV 19 1944

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 R. G. Taggart

Licensed Embalmer No. 25-63

P. O. Address King City 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.