

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED NOV 4 1947

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 4445

## 1. PLACE OF DEATH:

(a) County JACKSON  
 (b) City or town KANSAS CITY  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: FAIRMOUNT HOSPITAL 0  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 17 DAYS  
 (Specify whether years, months or days)  
 In this community 17 DAYS

3. (a) PRINT FULL NAME Samuel Spatter  
FAIRMOUNT HOSPITAL3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced S  
 6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive years  
 7. Birth date of deceased OCT 4 1947  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 17 hr. min.9. Birthplace KANSAS CITY MO 0  
(City, town, or county) (State or foreign country)10. Usual occupation X

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_ 9  
 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 14. Maiden name SUANITA BACHTEL  
 15. Birthplace OAKLAND MD.  
 (City, town, or county) (State or foreign country)

16. (a) Informant FAIRMOUNT HOSPITAL(b) Address 1414 E 2717. (a) Burial (b) Date thereof Oct-24-47  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Green Lawn18. (a) Signature of funeral director A. P. Doehler(b) Address 1415 East 1519. (a) 10-24-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 46  
 (c) City or town KANSAS CITY 3  
 (If outside city or town limits, write "RURAL") 8  
 (d) Street No. 1414 E 27 0  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 21  
year 1947 hour 4 minute 20 A. M.21. I hereby certify that I attended the deceased from OCT 4  
1947, to OCT 21, 1947;  
that I last saw him alive on OCT 20, 1947;  
and that death occurred on the date and hour stated above.

Immediate cause of death

Purp. nephritis acuta  
(n. m. e.)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_Of autopsy yes

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 [Signature] (M. D. or other) \_\_\_\_\_Address 315 Brookside signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**