

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 9 1952
BIRTH NO. 757-52 REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3010 Registrar's No. 38

1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Cape Girardeau</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Jopell</u>	
c. LENGTH OF STAY (In this place) <u>59 Min</u>		d. STREET ADDRESS (If rural, give locality) <u>St Francis Hosp.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>ALLEN</u> c. (Last) <u>SPRENGER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>FEB 1 1952</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>FEB 1 1952</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 1 YEAR Hours <u>0</u> Min <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cape Girardeau, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>

13a. FATHER'S NAME <u>Glean Sprenger</u>	13b. MOTHER'S MAIDEN NAME <u>Betty Hagan</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Glean Sprenger</u>	ADDRESS <u>Jopell Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>pre-maturity</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>776X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>None</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>None</u>
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22. I hereby certify that I attended the deceased from 2-1-1952 to 2-1-1952, that I last saw the deceased alive on 2-1-1952, and that death occurred at 2 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Deed or title) <u>D. K. ... MD</u>	23b. ADDRESS <u>711 Broadway Cape Girardeau</u>	23c. DATE SIGNED <u>2-1-52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-2-52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>	24d. LOCATION (City, town, or county) (State) <u>Illmo Mo</u>
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DATE REC'D BY LOCAL REG. <u>2-3-52</u>	REGISTRAR'S SIGNATURE <u>T. C. Summers</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Crystal Hoff</u>	ADDRESS <u>Illmo Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Oliver C. Amick

Licensed Embalmer No. 4470

P. O. Address Illmo, 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.