

FILED AUG 23 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26755

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 133

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|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Franklin.   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri. b. COUNTY Franklin.  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington.   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Washington. 0362   |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Francis Hospital.   |  | d. STREET ADDRESS (If rural, give location) 265 High St.  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) August b. (Middle) H. c. (Last) Sprick.  |  |   | 4. DATE OF DEATH (Month) (Day) (Year) Aug. 18th, 1954.                           |
| 5. SEX Male  | 6. COLOR OR RACE White   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married  | 8. DATE OF BIRTH Jan. 6th, 1869  |
| 9. AGE (In years last birthday) 85   |  | 10. MONTHS 7  | 11. DAYS 12  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming.   |  | 10b. KIND OF BUSINESS OR INDUSTRY Farming.  | 11. BIRTHPLACE (City and State or Foreign Country) Port Hudson, Mo.              |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 13a. FATHER'S NAME William Sprick.  |  |
| 13b. MOTHER'S MAIDEN NAME Katherine Depperman.   |  | 14. NAME OF DECEASED'S WIFE Sophia Sprick.  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. None.   |  | 16. SOCIAL SECURITY NO. None.   |  |
| 17. INFORMANT'S SIGNATURE OR NAME Mrs. Theo. Stegen  |  | ADDRESS Washington, Mo.   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.     |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia. Interval between ONSET and DEATH 3 days<br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) General infirmities of old age<br>DUE TO (c) Arterio-sclerotic G.V. Disease<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. Arterio-sclerotic gangrene of foot. |  |
| 19a. DATE OF OPERATION none  | 19b. MAJOR FINDINGS OF OPERATION None  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.   | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21f. HOW DID INJURY OCCUR?   |
| 22. I hereby certify that I attended the deceased from 29 Apr., 1952, to 18 Aug., 1954, that I last saw the deceased alive on 17 Aug., 1954, and that death occurred at 12:10 a. m., from the causes and on the date stated above. |  |   |  |
| 23a. SIGNATURE (Degree or title) Raymond J. Bogzo, M.D.  |  | 23b. ADDRESS Washington, Mo.  | 23c. DATE SIGNED 18 Aug 54   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial   | 24b. DATE Aug. 20, 1954.   | 24c. NAME OF CEMETERY OR CREMATORY Port Hudson Lutheran Eben. Cemetery, Port Hudson, Mo.  | 24d. LOCATION (City, town, or county) (State)                                    |
| DATE REC'D BY LOCAL REG. 8/19/54   | REGISTRAR'S SIGNATURE J.P. Neumann   | FUNERAL DIRECTOR'S SIGNATURE G. P. Neumann  | ADDRESS Pielburg & Vitt, Inc. Washington, Mo.                                    |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No. 2387

P. O. Address Washington, D.C.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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