

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5665

STATE FILE NUMBER

FILED MAR 4 1957

Registration District No. 261 Primary Registration District No. 5867 Registrar's No. 72

1. PLACE OF DEATH a. COUNTY <u>Nodaway County Missouri</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN <u>South of Parnell Missouri</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			c. CITY OR TOWN <u>Parnell Missouri</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>South of Parnell</u> Length of stay in 1b			d. STREET ADDRESS <u>none</u> (If outside, give location) <u>Rural</u>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Harrison Spoonemore</u>			4. DATE OF DEATH Month Day Year <u>February-22-1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August-22-1869</u>	9. AGE (In years last birthday) <u>87</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired farmer</u>		11. BIRTHPLACE (City and state or country) <u>Nodaway County Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>David Spoonemore</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Jane Grindstaff</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no none</u>		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT Address <u>Mrs Cloe Messner, Parnell Missouri</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tubercular Pneumonia</u> DUE TO (b) <u>Typh</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		20g. COUNTY STATE	
21. I attended the deceased from <u>7-19-57</u> to <u>7-22-57</u> and last saw ^{him} <u>him</u> alive on <u>7-21-57</u> Death occurred at <u>6:15 a. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>R. G. Foster DO</u>			22b. ADDRESS <u>Marionville Mo</u>		22c. DATE SIGNED <u>2-28-57</u>
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE <u>Feb 24-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sweet Home</u>	
23d. LOCATION (City, town, or county) <u>Ravenwood Mo</u>		23e. (State) <u>Mo</u>		24. FUNERAL DIRECTOR ADDRESS <u>John Andrews Grant City Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>3-2-57</u>		26. REGISTRAR'S SIGNATURE <u>Bess Holt</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

300-56

Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms which are related to diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

29-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by John Andrews, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John Andrews

Licensed Embalmer No. 42

P. O. Address Grant Co.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.