

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 8 1957

State File No. 20638

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

BIRTH NO. _____ REG. DIST. NO. 116 PRIMARY REG. DIST. NO. 3020 Registrar's No. 167

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY OR TOWN WASHINGTON		c. CITY OR TOWN SULLIVAN	
c. LENGTH OF STAY (in this place) 5 days		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL		e. STREET ADDRESS (If rural, give location) 438 Taylor 03610	
3. NAME OF DECEASED (Type or Print) a. (First) EMMA		b. (Middle) LEE	
c. (Last) SPURGEON		4. DATE OF DEATH (Month) (Day) (Year) June 29 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 10 1881
9. AGE (In years last birthday) 75	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Bourbon Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country)	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Stephen Bacon	13b. MOTHER'S MAIDEN NAME Mary Ann Shotwell	14. NAME OF HUSBAND OR WIFE James E. Spurgeon (dead)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Marion Spurgeon ADDRESS 8127 Elliot St. Averbond, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH 3 wks.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Blading Peptic Ulcer	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 204.1	
19c. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
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 June 9, 1957 , to June 29, 1957 , that I last saw the deceased alive on June 28, 1957 , and that death occurred at 6:30 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Robert M. Crawford M.D.		23b. ADDRESS Sullivan Mo	
23c. DATE SIGNED June 30 1957			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 2 1957	24c. NAME OF CEMETERY OR CREMATORY BACON Cemetery	24d. LOCATION (City, town, or county) (State) Bourbon MO.
DATE REC'D BY LOCAL REG. 1/2/57	REGISTRAR'S SIGNATURE R. E. Seidmann	25. FUNERAL DIRECTOR'S SIGNATURE Norman C. Stever ADDRESS Cuba Mo	

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.....
Signature of Student Embalmer

Signed *Norman C. Faene*.....

Licensed Embalmer No. *467*.....

P. O. Address *Cuba, N.Y.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.