

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-040330

STATE FILE NUMBER

AMENDED

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 272

FILED NOV 21 1961

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Osage</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton, Missouri</u>		Length of stay in lb <u>4 mo.</u>	c. CITY OR TOWN <u>Linn</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Tony</u> Middle <u>Greene</u> Last <u>Spurgeon</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>14</u> Year <u>1961</u>	
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/30/85</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>James Spurgeon</u>	13b. MOTHER'S MAIDEN NAME <u>Kathryn Blevins</u>	14. NAME OF HUSBAND OR WIFE <u>Mayme Spurgeon</u>
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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>unk</u>	14. SOCIAL SECURITY NO. <u>17</u>	INFORMANT Address <u>State Hospital Records Fulton, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral broncho pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Postoperative fracture of left hip</u>	
	DUE TO (c) <u>Cerebral Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.) <u>fell and fractured hip, left, 9/7/61</u>
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20c. TIME OF INJURY <u>?</u> Hour a.m. p.m.	Month, Day, Year <u>Sept. 7, 1961</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>State Hospital</u>	20f. CITY, TOWN, OR LOCATION <u>Fulton</u>	COUNTY <u>Callaway</u>	STATE <u>Mo</u>
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21. I attended the deceased from <u>State Hospital No. 1 July 6, 1961</u> to <u>Nov. 14, 1961</u> and I certify that the death occurred at <u>5:03 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>William V. Torricelli MD</u>	22b. ADDRESS <u>State Hospital No. 1, Fulton, Mo</u>	22c. DATE SIGNED <u>11/14/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-16-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY SEA.</u>	23d. LOCATION (City, town, or county) (State) <u>OWENSVILLE MO.</u>
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24. FUNERAL DIRECTOR <u>GOTTENSTRASSE FUNERAL HOME</u>	ADDRESS <u>Welford 747 W. Winta, Owensville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Nov-14-1961</u>	26. REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 7 1961

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 Merford H. W. Wain

Licensed Embalmer No. 3838

P. O. Address OWEN SU.

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.