

CERTIFICATE OF DEATH

DO NOT WRITE ON THIS STUB

VS 300
Rev. 11/72

FILED

JAN 10 1974

Registration District No. _____

Registrar's No. _____

| | | | | | | |
|--|--|---|--|--|---|------------------------------|
| DECEASED—NAME FIRST MIDDLE LAST John T. Spurgeon | | | SEX male | DATE OF DEATH (MONTH, DAY, YEAR) Dec. 29, 1973 | | |
| RACE WHITE, NEGRO, AMERICAN INDIAN, ETC. (SPECIFY) White | | AGE—LAST BIRTHDAY (YEARS) Mo. 82 Yr. _____ | UNDER 1 YEAR Mo. _____ | UNDER 1 DAY HOURS _____ MIN. _____ | DATE OF BIRTH (MONTH, DAY, YEAR) Jan. 26, 1891 | COUNTY OF DEATH 7a. _____ |
| CITY, TOWN, OR LOCATION OF DEATH Missouri (ST. LOUIS) | | | HOSPITAL OR OTHER INSTITUTION—NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER) Firmin Desloge Hospital | | | |
| STATE OF BIRTH (IF NOT IN U.S.A., NAME COUNTRY) Missouri | | CITIZEN OF WHAT COUNTRY USA | MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY) married | | SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME) Lela nee McClintock | |
| SOCIAL SECURITY NUMBER 497-16-0858 | | USUAL OCCUPATION (GIVE KIND OF WORK DONE DURING MOST OF WORKING LIFE, EVEN IF RETIRED) Retired | | KIND OF BUSINESS OR INDUSTRY | | |
| RESIDENCE—STATE COUNTY Mo. | | CITY, TOWN, OR LOCATION, ZIP CODE St. Louis | INSIDE CITY LIMITS (SPECIFY YES OR NO) YES | TOWNSHIP 14d | STREET AND NUMBER 607 Bates St. | |
| FATHER—NAME FIRST MIDDLE LAST Henry Spurgeon | | | MOTHER—MAIDEN NAME FIRST MIDDLE LAST Ellen Wilson | | | |
| INFORMANT—NAME Lela Spurgeon | | | MAILING ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) 607 Bates St., St. Louis 11, Missouri | | | |
| PART I. DEATH WAS CAUSED BY: [ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c)] | | | | | | |
| IMMEDIATE CAUSE (a) Right Solar pneumonia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| DUE TO, OR AS A CONSEQUENCE OF: (b) Generalized arterio sclerosis | | | | | ? | |
| DUE TO, OR AS A CONSEQUENCE OF: (c) Old CVA & right sided Hemiplegia | | | | | 2 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a) (b) (c) arterio sclerosis head area. Ch. Brain Syndrome | | | | | | |
| ACCIDENT, SUICIDE, HOMICIDE, OR UNDETERMINED (SPECIFY) | | DATE OF INJURY (MONTH, DAY, YEAR) | HOUR | HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART I OR PART II, ITEM 18) | | |
| INJURY AT WORK (SPECIFY YES OR NO) | | PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BLDG., ETC. (SPECIFY) | LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, STATE) | IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> LINK | | |
| CERTIFICATION—PHYSICIAN: I ATTENDED THE DECEASED FROM 11-8-73 TO 12-28-73 | | AND LAST SAW HIM/HER ALIVE ON 12-28-73 | I DID/DID NOT VIEW THE BODY AFTER DEATH. | | DEATH OCCURRED AT THE PLACE, ON THE DATE, AND, TO THE BEST OF MY KNOWLEDGE, DUE TO THE CAUSE(S) STATED. | |
| CERTIFICATION—MEDICAL EXAMINER OR CORONER: ON THE BASIS OF THE EXAMINATION OF THE BODY AND/OR THE INVESTIGATION, IN MY OPINION, DEATH OCCURRED ON THE DATE AND DUE TO THE CAUSE(S) STATED. | | | | | | |
| CERTIFIER—NAME (TYPE OR PRINT) MAX STARBUCK | | MO. LICENSE NO. 20818 | SIGNATURE <i>Max Starbuck M.D.</i> | REG. OR TITLE DR | DATE SIGNED (MONTH, DAY, YEAR) 12-29-73 | |
| MAILING ADDRESS—CERTIFIER 6304 S. Grand Ave | | STREET OR R.F.D. NO. | CITY OR TOWN St. Louis | STATE Mo | 63111 | |
| BURIAL, CREMATION, REMOVAL (SPECIFY) removal | | CEMETERY OR CREMATORY—NAME Motor Parkview Cem. | | LOCATION CITY OR TOWN STATE Farmington, Mo. | | |
| DATE 12-30-73 | | FUNERAL HOME—NAME AND ADDRESS (STREET OR R.F.D. NO., CITY OR TOWN, STATE, ZIP) Southern Funeral Home: 6322 S. Grand, St. Louis, Mo. | | | | |
| FUNERAL DIRECTOR—SIGNATURE <i>James Deaver</i> | | REG. NO. 9149 | REGISTRAR'S SIGNATURE <i>John H. Brung, M.D.</i> | DATE RECEIVED BY LOCAL REGISTRAR DEC 31 1973 | | |

DECEASED

USUAL RESIDENCE WHERE DECEASED LIVED. IF DEATH OCCURRED IN INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION.

PARENTS

CAUSE

CERTIFIER

BURIAL

7b-c. **3875**
7d. **10117**
8. **29**
14a. **29**
14b. **510**
14c-d. **3875**
14e. **155**
23. **0020818**
26a. _____
18-U. **4369**
18-S-1. **4**
18-S-2. _____
20a-f. _____
20g-St. _____
20g-Co. _____
20g-Cy. _____

Type or print in PERMANENT BLACK INK. See handbook for instructions.

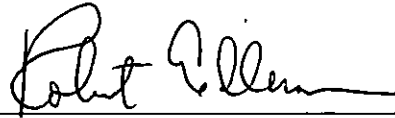
STATEMENT BY LICENSED EMBALMER

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



Licensed Embalmer No. 5400

P. O. Address Mount No

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.