

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

9574

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. 31259 Lacland)

File No.

Registered No. 2056 St. Ward)

2. FULL NAME

Minnie Spencer

(a) Residence No. 31259 Lacland St. 16 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OF (OR) WIFE OF

Eliead Spencer

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

8-16-1851

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

75

6

15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

10. NAME OF FATHER

unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown

12. MAIDEN NAME OF MOTHER

unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

unknown.

14.

INFORMANT Dr. Walter Spencer
(Address) 31259 Lacland.

15.

FILED MAR -1 1927 Max Starkoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-1 1927

17. I HEREBY CERTIFY That I attended deceased from March 1, 1927 to March 1, 1927 that I last saw her alive on July 28, 1927, and that death occurred, on the date stated above, at 1230 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

arterial sclerosis
815
Paralysis agitans (duration) 10 yrs. mos. da.
CONTRIBUTORY (SECONDARY) 5 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical

(Signed) John C. Falk M. D.

(Address) 4568 Lafayette

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **DATE OF BURIAL**

Kathalia Cem Mar 3 1927

20. UNDERTAKER **ADDRESS**

A. Ron L. UG 3703 North Grand.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

