

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

Do not use this space.

23185

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1. PLACE OF DEATH
 County Jasper Registration District No. 416
 Township _____ Primary Registration District No. 4-2-48
 City Sarcoxie (No. _____) St. _____ Ward _____

2. FULL NAME James M. Spencer
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF E. Jane Spencer

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 7, 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
84 4 24

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Van Buren Arkansas
 13. NAME Elajah Spencer
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER
 15. MAIDEN NAME De Wisse
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT W. D. Hurron
 (ADDRESS) Sarcoxie Mo

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Yakley Cemetery DATE 8/3 1932

19. UNDERTAKER W. H. Engelen
 (ADDRESS) Sarcoxie Mo

20. FILED Aug 1 1932 Long Registrar

1 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 31, 1932

22. I HEREBY CERTIFY That I attended deceased from July 27, 1932 to July 31, 1932.
 I last saw him alive on July 29, 1932. Death is said to have occurred on the date stated above, at 11:15 P.M.
 The principal cause of death and related causes of importance were as follows:
Cerebral Apoplexy Date of onset 7-27-32
82A
J. W. Boyd
 Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) J. W. Boyd, M. D.
 (Address) Sarcoxie Mo

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.

AUG 24 1932

