

MISOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

MAY 15 1937

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 15444
Township Kaw Primary Registration District No. 1002 Registered No. 61255
City no mo (No. Lakeside Hospital St. _____ Ward _____)

2. FULL NAME

Infant Smith Spencer
(a) Residence No. 3228 St. Benton 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 19 1937

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

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw h..... alive on....., 19____, and that death occurred, on the date stated above, at..... 3:40 p.m. m. 4-19-37

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 18-37

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 7 hrs. or — min.

atletic - st. lung.
161a (duration) _____ yrs. _____ mos. _____ da.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____

CONTRIBUTORY Dyspnoea (SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

9. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY) Mo.

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

10. NAME OF FATHER withheld

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) unknown

WAS THERE AN AUTOPSY? yes

12. MAIDEN NAME OF MOTHER Maie Spencer

WHAT TEST CONFIRMED DIAGNOSIS? Inspection

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kennett, Mo.

(Signed) Margaret Jones, M. D., 19 (Address) 3620 Truist

*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.

14. INFORMANT (Address) Lakeside Hospital

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Floral Hills DATE OF BURIAL 4/27 1937

15. FILED 4/27 1937 M. M. Brown REGISTRAR

20. UNDERTAKER O.V. Mast Funeral Home ADDRESS _____

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.

