

REC'D APR 11 1938

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

9222
Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City St. Louis (d) Street No. City Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 65 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 791
Primary Registration District No. 1003 Registered No. 2811

2. PRINT FULL NAME

William Forgie Spencer / 5-2
(a) Residence, No. 1730 Missouri St. 23
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 5, 1868

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 0 18

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

FATHER 13. NAME Bushrod Spencer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

MOTHER 15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT (ADDRESS) Effie Spencer
1730 Missouri

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Peters Cem. DATE 3/25/38 19.

19. FUNERAL DIRECTOR (ADDRESS) Allen W. McLaughlin
2301 Lafayette Ave.

20. FILER J.P. Bradeck Local Registrar.

MAR 25 1938

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/23/38 19

22. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....

I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at 11:45 P.M.

The principal cause of death and related causes of importance were as follows:

Cerebral Anoplexy.
Arteriosclerosis.

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? No

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? No

If so, specify.....

(Signed) Joseph T. Deane M.D.

(Address) Deane

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.

STATEMENT BY LICENSED EMBALMER

I, L. R. Cooper, Licensed Embalmer No. 3633

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E. me

No..... or by..... Registered Apprentice No.....
working under my personal supervision.

Signed L. R. Cooper
Licensed Embalmer No. 3633

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.)