

# STANDARD CERTIFICATE OF DEATH

Registered No. 6877

MAR 20 1939

**PLACE OF DEATH:**

County Jasper *Reg Dist 415* State Missouri

Township Reeds *Dist. Reg Dist 4247* City or village Reeds No. \_\_\_\_\_ St., \_\_\_\_\_ Ward.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

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

**FULL NAME** Edith Spencer

Residence: No. Reeds Mo. St., \_\_\_\_\_ Ward. \_\_\_\_\_

(Usual place of abode)

(If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
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21. DATE OF DEATH (month, day, and year) Feb 18 1939

If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of  
Parker S. Spencer.

22. I HEREBY CERTIFY, that I attended deceased from  
Feb 1 1939, to Feb 18 1939

I last saw her alive on Feb 17 1939 death is said to have occurred on the date stated above, at 9 P. m.

DATE OF BIRTH (month, day, and year)  
AGE

Years	Months	Days	If LESS than 1 day, hrs. or mins.
<u>73</u>	<u>9</u>	<u>6</u>	

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

Angina Pectoris

Date of onset

8. Trade, profession, or particular kind of work done as spinner, sawyer, bookkeeper, etc. Housework.

Other contributory causes of importance: None

9. Industry or business in which work was done, as silk mill, sawmill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town and State or country):

Reeds, Mo.

13. NAME: W. T. Hine

14. BIRTHPLACE (city or town and State or country): Unknown

15. MAIDEN NAME: Unknown

16. BIRTHPLACE (city or town and State or country): Unknown.

17. INFORMANT (name and address):

Parker S. Spencer, Reeds, Mo.

18. BURIAL, CREMATION, OR REMOVAL:

Place Reeds, Mo. Date 2-21-39, 1939

19. UNDERTAKER (name and address):

Durnil Funeral Home, Pichef, Okla.

20. FILED 2/21 1939 Scott Bragdon Registrar

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_  
(Signed) Luzoy Summers  
373 (Address) Jefferson, Mo.

RECEIVED

District Health Officer No. 6,

District File Number 6-39-664

Date Filed MAR 16 1939

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

6877  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jasper Registration District No. 415  
 (b) Township Reeds Primary Registration District No. 4247  
 (c) City Reeds (d) Street No. \_\_\_\_\_ 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Edith Spencer  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 22, 1865

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hr. or _____ min.
<u>73</u>	<u>9</u>	<u>6</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

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) \_\_\_\_\_

FATHER

13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

MOTHER

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED 7/21 1939 Hest Beagdon Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-18 1939

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 \_\_\_\_\_ m.

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

Date of onset \_\_\_\_\_

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) Leroy Simmons, M. D.  
 (Address) Sarpsville Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

COUNCIL OF DEPARTMENTS OF HEALTH AND HUMAN SERVICES

