

Registration District No. 07

Primary Registration District No. 5806

Registrar's No. 33

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town Portageville Mo  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Robert Bob Spencer

3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex m. 5. Color or race w. 6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife Archie 6. (c) Age at death of wife Archie Spencer alive \_\_\_\_\_ years

7. Birth date of deceased Don't know  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
71 about hr. min.

9. Birthplace Dyer Co. Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Too old to work now

12. Name Don't know

13. Birthplace "  
(City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Guthen Spencer

(b) Address Portageville Mo.

17. (a) Marston (b) Date thereof Aug 6 1939  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place of burial John Halliday

18. (a) Signature of funeral director R M Payne

(b) Address Portageville 535

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid  
(c) City or town Portageville Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 5th, 1939 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from Only on Aug. 4, 1939, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on August 4, 1939, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Volvulus Duration About 4 days  
Due to No definitely known cause except old age and irregular bowels

Due to None  
Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: No operation  
Of operations  
Of autopsy None  
PHYSICIAN  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature A H Reeder (M. D. or other) Address Portageville, Mo Date signed 8-6-39

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 hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

26327

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 607  
 (b) Township Portageville Primary Registration District No. 4361  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 (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

Robert Bob Spence  
 (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

MEDICAL CERTIFICATE OF DEATH

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

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

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

7. AGE YEARS 71 MONTHS \_\_\_\_\_ DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 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) Tenn Tenn

FATHER 13. NAME Unknown

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Luther Spence Portageville Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Marston DATE 8-6 1939

19. FUNERAL DIRECTOR (ADDRESS) John H. Hester Portageville

20. FILED Aug 22, 1939 May W. Cook Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 5, 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1939 to Aug 4, 1939  
 I last saw him alive on July 19, 1939 Death is said to have occurred on the date stated above, at 3 P. M.  
 The principal cause of death and related causes of importance were as follows:

Valerius asthma not  
not definitely known  
cause except old age  
 Other contributory causes of importance:  
and irregular bowels

Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis? none 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) A. A. Reider, M. D.  
 (Address) Portageville, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAWS. CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-26327

1939