No. 2
1-10-39
17-39
X21492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 2 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1145

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 130

1. PLACE OF DEATH:

(a) County Jackson 2

(b) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 6527 Summit
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 25 years
years, months or days) 152

3. (a) PRINT FULL NAME Nellie Maud Spencer

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

4. Sex Female 5. Color or race White 6. (a) ~~Single, widowed~~, married, ~~divorced~~ Married

6. (b) Name of husband or wife E J Spencer 6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased December (Month) 1 (Day) 1868 (Year)

8. AGE: Years 71 Months 1 Days 9 If less than one day ____ hr. ____ min.

9. Birthplace Bloomington Illinois (City, town, or county) Illinois (State or foreign country)

10. Usual occupation House Wife 1

11. Industry or business " " 1

FATHER
12. Name James Keeney 9
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name Unknown 1
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant James E Spencer
(b) Address 6527 Summit K.C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Moriah

18. (a) Signature of funeral director Ott E Mitchell
(b) Address 310 N. Main St. Independence Mo

19. (a) Dec. 10, 1940 (Date received local registrar) (b) N M Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Mo
(If outside city or town limits write "RURAL")

(d) Street No. 6527 Summit
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 1 day 10th year 1940 hour 3 minute 7 A.M.

21. I hereby certify that I attended the deceased from Feb 5th 1939, 19__, to Jan 9, 1940
that I last saw her alive on Jan. 9th, 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to Long confinement in bed	48 hrs
Due to 1862	18
Other conditions Intrachanteric fracture (Include pregnancy within 3 months of death)	
Major findings: Of operations not applicable	
Of autopsy not applicable	

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) accidentally fell in home
(b) Date of occurrence Feb. 4. 1939
(c) Where did injury occur? at home 510. S Main St Independence Mo. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)
While at work? yes (e) Means of injury fall

23. Signature C B Francisco (M. D. or other)
Address 623 Argyle Bldg Date signed 1-10-40 KC Mo.

(Licensed Embalmer's Statement on Reverse Side)

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 R. B. Mitchell

Licensed Embalmer No. 646

P. O. Address 310 N. Main St. Indy, C

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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