

FILED MAR 3 - 1940

Registration District No. 790 Primary Registration District No. 4 Registrar's No. _____

1. PLACE OF DEATH: Saline
 (a) County Saline
 (b) City or town Slater
 (c) Name of hospital or institution: none
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 28 years (Specify whether years, months or days)
 In this community _____

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Saline
 (c) City or town Slater
 (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.

3. (a) PRINT FULL NAME William Neale Spencer
 3. (b) If veteran, name war no 3. (c) Social Security No. _____
 4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife Luth Spencer 6. (c) Age of husband or wife if alive 55 years
 7. Birth date of deceased November 13 1878
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb. day 5th
 year 1940 hour 4 minute a M.
 21. I hereby certify that I attended the deceased from January 27 1939 to Feb 5 1940
 that I last saw him alive on Feb 1 1940
 and that death occurred on the date and hour stated above.

8. AGE: Years 61 Months 2 Days 13 If less than one day hr. _____ min. _____
 9. Birthplace Otterville, Mo.
 (City, town, or county) (State or foreign country)
 10. Usual occupation Locomotive Engineer

Immediate cause of death Angina Pectoris
 Due to Chr. Asthma
Chr. myocarditis
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) None

11. Industry or business _____
 MOTHER FATHER { 12. Name William R. Spencer
 13. Birthplace Ohio.
 14. Maiden name Margaret Neale
 15. Birthplace Mo.

Major findings: Of operations _____
 Of autopsy not done
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Frank Spencer
 (b) Address Slater, Mo.
 17. (a) burial (b) Date thereof 2-7-40
 (Burial, cremation, or otherwise) (Month) (Day) (Year)
 (c) Place: burial or cremation Slater, Mo.
 18. (a) Signature of funeral director Hill Brothers
 (b) Address Slater, Mo.
 19. (a) Feb 6 (b) W. M. Tuttle
 (Date received local registrar) (Registrar's signature)

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? _____
 (Specify type of place) (e) Means of injury _____
 23. Signature W. A. McJurney (M. D. or other) _____
 Address Slater, Mo. Date signed 2/6/40

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

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.

RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE: 2-4-1961

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

Edgar Moore

Registered Apprentice No. **230**

working under my personal supervision.

Signed

A. C. Hill

Licensed Embalmer No. **3090**

P. O. Address **Slater, Mo.**

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.