

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

23582

State File No. \_\_\_\_\_

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6027

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution Missouri Pacific Hosp, 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 weeks (Specify whether  
In this community 4 weeks years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Alabama County \_\_\_\_\_  
(c) City or town Mobile (If outside city or town limits write "RURAL") N.R.  
(d) Street No. #1456 Dauphin (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17  
year 1940 hour 8 minute 40 P. M.  
21. I hereby certify that I attended the deceased from June  
17, 1940, to July 17, 1940  
that I last saw h. in alive on July 17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertension Cardio-Vascular  
Chronic Myocarditis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Ch. Sinusitis & Prostatitis  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 W. J. Polk (M. D. or other) \_\_\_\_\_  
Address Mo. Polk's Hospital Date signed \_\_\_\_\_

8. (a) PRINT FULL NAME Frank E. Spencer  
8. (b) If veteran, 718-05-1874 name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Martha E. Spencer 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased January 19 - 1880 (Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Cairo, Ill. (City, town, or county) (State or foreign country)

10. Usual occupation Chief Clerk, Int. Dept.

11. Industry or business Mr. O. R. R.

MOTHER FATHER { 12. Name Frank Spencer  
18. Birthplace Ill. (City, town, or county) (State or foreign country)  
14. Maiden name Abbie East  
15. Birthplace Ill. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. F. E. Spencer

(b) Address Mobile, Alabama

17. (a) Removal (b) Date thereof 7-18-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Mobile, Alabama

18. (a) Signature of funeral director C. R. Lupton & Sons

(b) Address #7233 Delmar Blvd

19. (a) JUL 19 1940 (b) J. F. Fredrick (Date received local registrar) (Registrar's signature)

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

**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 Clarence H. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis, 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.**