

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 2617

Primary Registration District No. 1003

Registration District No. 318

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution From March 15 to March 16
(Specify whether years, months or days)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Dr. Walter Scott Spencer

3. (b) If veteran, name war _____ No. _____

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 Ella Travers Spencer

6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased February 24, 1875
(Month) (Day) (Year)

8. AGE: Years 69 Months - Days 22
If less than one day hr. min.

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

10. Usual occupation Doctor of dental surgery

11. Industry or business General practice

12. Name Dr. Elias Lewis

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

14. Maiden name Minnie Gimble

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

16. (a) Informant Mrs. Charles T. Morris

(b) Address 1609a Page Blvd.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 3/20/44
(Month) (Day) (Year)

(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address Clayton Rd. at Concordia Lane

19. (a) MAR 19 1944
(Date received local registrar)

J. F. Bredbeck
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1609 Page Blvd.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 16
year 1944 hour 10 minute 40 P.M.

21. I hereby certify that I attended the deceased from March 15th 1944
March 16, 1944, to 3/16/44, 1944.

that I last saw him alive on 3/16/44, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death acute Bowel obstruction from a large gall stone

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Large Gall Stone in small intestine

Of operations _____

Of autopsy None

Duration _____

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 5

23. Signature Charles H. Buchanan (M. D. or D.V.M.)

Address 5183 Cabanne Ave. Date signed 3/17/44

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. 1994
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, fact should be so stated above.