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FILED MAY 23 1944  
Registration District No. 49

Primary Registration District No. 1002

State File No. 2079  
Registrar's No.

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

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
K. C. General Hospital No. 10  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 26 days  
(Specify whether  
 In this community 36 years  
years, months or days)

3. (a) PRINT FULL NAME Charles W. Spencer  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Divorced  
 6. (b) Name of husband or wife Don't know 6. (c) Age of husband or wife if alive years  
 7. Birth date of deceased Aug. 7 - 1885  
(Month) (Day) (Year)

8. AGE: Years 58 Months 9 Days 10 If less than one day hr. min.

9. Birthplace Kansas  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Barber

MOTHER FATHER  
 11. Industry or business  
 12. Name William Spencer  
 13. Birthplace Kansas  
(City, town, or county) (State or foreign country)  
 14. Maiden name Alice Setwick  
 15. Birthplace Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Gordon B. Spencer  
 (b) Address 229 N. 18th St.  
 17. (a) Buried (b) Date thereof Nov 11 1944  
(Burial, exhumation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Maple Hill

18. (a) Signature of funeral director V. E. Brown  
 (b) Address K.C. 14  
 19. (a) 5-8-44 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Jackson 48  
 (c) City or town Kansas City 5  
(If outside city or town limits, write "RURAL") 8  
 (d) Street No. 1326 Bellefontaine  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8  
 year 1944 hour 11 minute 55 P.M.  
 21. I hereby certify that I attended the deceased from April 12, 1944, to May 8, 1944  
 that I last saw him alive on May 8, 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease  
 Duration

Due to  
 Due to  
 Other conditions (Include pregnancy within 3 months of death) 93d

Major findings: Of operations 93d  
 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 plague) (c) Means of injury  
 23. Signature D. E. Upster (M. D. or other) M.D.  
 Address Med. Dir. Gen'l Hosp. Date signed 5-8-44

**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..... *John C. Libon*.....  
Licensed Embalmer, No. *3135*.....  
P. O. Address..... *Kanun Cg. Hama*.....

**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.**