

FILED NOV 14 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 33487  
Registrar's No. 4369

Registration District No. 199

Primary Registration District No. 1002

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: Gen. Hosp. #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 10-12-44-10-28-44  
(Specify whether years, months or days) Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1522 Euclid  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME EMMALINE SPENCER

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced 2 Wid  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased AUG. \_\_\_\_\_ 1882  
(Month) (Day) (Year)

8. AGE: Years 62 Months 2 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Unemployed

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Washington Spencer  
13. Birthplace Texas  
(City, town, or county) (State or foreign country)  
14. Maiden name Branham  
15. Birthplace Texas  
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk  
(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 11-3-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Blue Ridge

18. (a) Signature of funeral director Adkins Bros  
(b) Address 2000 E. 17th St. K.C. Mo.

19. (a) 10-30-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28  
year 1944 hour 5:40 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Oct. 12  
1944 to Oct. 28 1944  
that I last saw her er. alive on Oct. 28 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive type heart disease with decompensation. Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to 93 d.

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy Same as above  
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) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other)  
Address Gen. Hosp. #2, 600 E. 22nd Date signed 10-30-44

**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..... *A. T. Moore* .....

Licensed Embalmer No: *948* .....

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.**