

FILED DEC 15 1944

State File No. ....

10408

Registration District No. ....

Primary Registration District No. ....

Registrar's No. ....

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri  
 (b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St. Louis City Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 2 mos-17 days  
(Specify whether)  
 In this community 27 years  
years, months or days)

3. (a) PRINT FULL NAME Louis N. Spencer

3. (b) If veteran, name war Unk 3. (c) Social Security No. unk

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widower  
 6. (b) Name of husband or wife unk 6. (c) Age of husband or wife if alive no years  
 7. Birth date of deceased April 13th, 1882  
(Month) (Day) (Year)

8. AGE: Years 62 Months 7 Days 3 If less than one day  
hr. min.

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

10. Usual occupation Chef

11. Industry or business

MOTHER FATHER { 12. Name AMOS  
 13. Birthplace Ohio  
(City, town, or county) (State or foreign country)  
 14. Maiden name Malinda  
 15. Birthplace Dressing - Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant M. Renard  
 (b) Address St. Louis City Hospital

17. (a) ~~burial~~ cremation, or removal (b) Date thereof 12-7-44  
(Month) (Day) (Year)

(c) Place: City Crematory

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital No. 1

19. (a) DEC 6 1944 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mad  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5185 Delmar Ave.  
(If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16th  
 year 1944 hour 2:15 minute P. M.  
8/30/44

21. I hereby certify that I attended the deceased from Nov. 16th 19 44  
 to Nov. 16th 19 44  
 that I last saw h im alive on Nov. 16th 19 44  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchogenic carcinoma Duration  
e

Due to

Due to H/I

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

Major findings: Of operations

Of autopsy Same

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 \_\_\_\_\_

23. Signature Herbert E. Fitz (M. D. or other) 0  
 Address 1515 Lafayette Date signed 11/16/44

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**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.....

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.**