V. S. No. 2
50M—5-42
Rev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

37257

FILED NOV 19 1945

State File No.

Registration District No. 124

Primary Registration District No. 5459

Registrar's No.

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural - Willard, Mo. Outer city
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ~~Rt.2, Willard, Mo.~~
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 59 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Willard, Mo. Rt.2 0
(If outside city or town limits, write "RURAL")

(d) Street No. Rt.2, Willard, Mo. 0
(If rural, give location)

(e) Citizen of foreign country? No. 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mrs Josephine Spencer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F M 1

5. Color or race White

6. (a) Single, widowed, married, divorced 2 Widow

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept. (Month) 17th (Day) 1866 (Year)

8. AGE:

Years	Months	Days	If less than one day
79	1	10	hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name ? ? Sweezy.
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 1 (State or foreign country)

16. (a) Informant ~~Unknown~~ Ethan Spencer
(b) Address Rt.2 Willard, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-~~30~~ 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Liberty

18. (a) Signature of funeral director ~~[illegible]~~ W.L.Dunn
(b) Address Springfield, Mo.

19. (a) 10-4-45 (Date received local registrar) (b) Jewell Williams (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 27 th.
year 1945 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from Aug 1 - 45 , 19 , to Sept 27 , 1945
that I last saw her alive on Sept 4 , 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of bowells of general years duration

Due to —

Due to —

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

Major findings:
Of operations none

Of autopsy no 46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 46

(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? (Specify type of place)

While at work? — (e) Means of injury —

23. Signature U F Kerr (M.D. or other)

Address 636 E Grand - Springfield Date signed Sept 28 45

1245

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Greene County Health Office
County File Number 45-11-84
Date Filed 11-12-45

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 O. W. McJackson

Licensed Embalmer No. 28-91

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.