

No. 7-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26371

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 904

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Sisters Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day
In this community 75 years (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Sallie Price Spencer
(b) If veteran, name war No
(c) Social Security No. None
(d) Sex Female
(e) Color or race White
(f) (a) Single, widowed, married, divorced Single
(g) (b) Name of husband or wife
(c) Age of husband or wife if alive 3 years 1860
7. Birth date of deceased Sept. 3 1860
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month August day 8
year 1946 hour 6 minute 28 P. M.
21. I hereby certify that I attended the deceased from 5 Aug 1946 to 6 Aug 1946
that I last saw her alive on 6 Aug 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Duration 2 days
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings: Of operations none Of autopsy none
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
PHYSICIAN Underline the cause to which death should be charged statistically.

8. AGE: Years 85 Months 11 Days 5 If less than one day
9. Birthplace Buchanan Co. Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business At Home
12. Name James L. Spencer, Sr.
13. Birthplace Buchanan Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Thomas
15. Birthplace Bourbon Co. Kentucky
(City, town, or county) (State or foreign country)
16. (a) Informant James L. Spencer Jr.
(b) Address Saxton, Mo.
17. (a) Burial (b) Date thereof 8/10/46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Mora Cemetery
18. (a) Signature of funeral director Heaton, Beale & Bowman
(b) Address St. Joseph, Mo.
19. (a) Aug. 13, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other) Address St. Joseph Mo Date signed 8-16-46

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

AUG 21 1946

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, ~~by~~.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Raymond W. Morehead*

Licensed Embalmer No. *4413*

P. O. Address *319 So 10th St Joseph, Mo*

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.

Registration District No. 42

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community _____
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Lillie P. Spencer

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Sept 3 1886
(Month) (Day) (Year)

8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1946 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 1946.
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to bronchopneumonia
arterio-sclerosis

Due to _____

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

Major findings:
Of operations _____

Of autopsy 107

Duration

1 week
1 year

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 _____ (M. D. or other)

Address St. Joseph MO Date signed 8/8/46

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

SUPPLEMENTARY

25217

26371