No. 2
12-45
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

15668

State File No.

FILED MAY 14 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4578

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mo. Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 6 0 9 5

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5971A Theodisia Ave., 0
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Carrie Belle Spencer.

3. (b) If veteran, name war No

3. (c) Social Security No. 489-10-4782

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Isaac B. Spencer

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased April 2, 1876.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
71	1	2	hr. min.

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

10. Usual occupation Maid in Dressing Room

11. Industry or business

FATHER
12. Name William Gleason
13. Birthplace Indiana
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lucella Hartle
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Hazel Warner
(b) Address 5971A Theodisia Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7/47.
(Month) (Day) (Year)

(c) Place: burial or cremation Lakewood Park Cem.,

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,

19. (a) MAY 5 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4
year 1947 hour 8.25 minute A.M.M.

21. I hereby certify that I attended the deceased from April 21, 1947, to May 4, 1947, that I last saw her alive on 5-4, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
1. Carcinoma liver	?
2. Lobular pneumonia (Terminal)	5 days
3. Chronic cholecystitis	?
4. Cholelithiasis	

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations no operation

Of autopsy Yes

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) no

(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? no (Specify type of place)

While at work? (e) Means of injury

23. Signature Janet A. Forsen M. D. or other

Address 3903 Olive Date signed 5-5-47

(Licensed Embalmer's Statement on Reverse Side)

Dr. J.A.Forsen
3903 Olive St.,

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 Alfred F. Boedeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamont Ave.,

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.