

FILED MAR 3 1950

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

5533

State File No.

BIRTH NO. _____ REG. DIST. NO. 241 PRIMARY REG. DIST. NO. 5829 Registrar's No. 8

1. PLACE OF DEATH
 a. COUNTY New Madrid
 b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Portage Twp
 c. LENGTH OF STAY (in this place)
 d. FULL NAME OF HOSPITAL OR INSTITUTION Albert Beis Farm

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
 a. STATE Mo. b. COUNTY New Madrid
 c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural - Portage Twp
 d. STREET ADDRESS (If rural, give location) Albert Beis Farm

3. NAME OF DECEASED
 a. (First) Luther b. (Middle) _____ c. (Last) Spencer

4. DATE OF DEATH (Month) (Day) (Year)
Jan 31, 1950

5. SEX Male **6. COLOR OR RACE** White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Dec. 16, 1900

9. AGE (In years last birthday) 49 IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 4 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming

10b. KIND OF BUSINESS, OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Tenn

12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Robert D. Spencer

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE Zora B. Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME Herchel Hadair - Jay Wye **ADDRESS** Mo

18. CAUSE OF DEATH
 Enter only one cause per line for (a), (b), and (c)
 *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage
ANTECEDENT CAUSES
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension
 DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

19c. INTERVAL BETWEEN ONSET AND DEATH 1 da.

8 31 X

20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 31, 1950, to Jan. 31, 1950, that I last saw the deceased alive on Jan. 31, 1950 and that death occurred at 4:30 P.M. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John J. Killian M.D.

23b. ADDRESS Portageville, Mo

23c. DATE SIGNED 2-3-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Buried

24b. DATE Feb 4, 1950

24c. NAME OF CEMETERY OR CREMATORY Portageville

24d. LOCATION (City, town, or county) (State) Portageville, Mo

DATE REC'D BY LOCAL REG. Feb 3 1950

REGISTRAR'S SIGNATURE Ellen De Lisle

25. FUNERAL DIRECTOR'S SIGNATURE Dehile Funeral Parlor - Portageville, Mo

ADDRESS

RECEIVED FEB 23 19
District Health Office No
District File Number 250-1
File Filed

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.....

Not Embalmed

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

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.