S. No. 300
v. 10.48

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11123
2252

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis 22
d. STREET ADDRESS (If rural, give location): 218 S 4th

3. NAME OF DECEASED (Type or Print)
a. (First): Ulysses
b. (Middle): Grant
c. (Last): Spence

4. DATE OF DEATH (Month) (Day) (Year): March 7, 1950

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: March 4, 1868
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Painter
11. BIRTHPLACE (State or foreign country): Aledo, Ill.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: James Reed Spence
13b. MOTHER'S MAIDEN NAME: Mary Haskins
14. NAME OF HUSBAND OR WIFE: Elizabeth Spence

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Clark G. Spence, Colona, Ill., Box 93

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) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cirrhosis of Liver
DUE TO (c) Arterio sclerosis

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
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): 5810
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
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 _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 12:15A m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Patrick E Taylor Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 3 7 50

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 3-7-50
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Aledo, Ill.

DATE REC'D BY LOCAL REG.: MAR 8 1950
REGISTRAR'S SIGNATURE: J. B. Pasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

2252

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 me

working under my personal supervision.

Student Embalmer No.....

Signed William S. Salter

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address Ol Chaka, 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.