

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10098**
Registrar's No. **1388**

FILED MAR 27 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1602

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (in this place) 35 yrs.		d. STREET ADDRESS (If rural, give location) 4600 E. 23rd. St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Erwin b. (Middle) B. c. (Last) Spencer			4. DATE OF DEATH (Month) (Day) (Year) Mar. 6, 1953		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Feb. 4, 1891		9. AGE (In years last birthday) 62		10. UNDER 1 YEAR Months _____ Days _____	
11. UNDER 1 YEAR Hours _____ Mins. _____		12. BIRTHPLACE (City and State or Foreign Country) Canton, Minn.		13. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INTERIOR DECORATING Schmidt & Co.			

13a. FATHER'S NAME William W. Spencer		13b. MOTHER'S MAIDEN NAME Mary Marcella Baynton		14. NAME OF HUSBAND OR WIFE Edith M. Spencer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 487-07-3900		17. INFORMANT'S SIGNATURE OR NAME Bob Spencer ADDRESS 4600 E. 23rd. St.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral hemorrhage left internal capsule 1 month		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH unknown	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		DUE TO (b) cerebral arteriosclerosis			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				331K	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR	

22. I hereby certify that I attended the deceased from 1-31, 1953, to 3-6, 1953, that I last saw the deceased alive on 3-6, 1953, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE Richard W. Gunn (Degree or title) M.D.		23b. ADDRESS 6230 Truman Rd. K.C. Mo.		23c. DATE SIGNED 3-7-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/9/53		24c. NAME OF CEMETERY OR CREMATORY Floral Hills Ceme.	
				24d. LOCATION (City, town, or county) (State) Kansas City, Missouri	

DATE REC'D BY LOCAL REG. 3-7-53		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE Earp & Sons ADDRESS 4139 Truman Rd. K.C. Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed William H. Eary

Licensed Embalmer No. 4728

P. O. Address K. P. 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.