

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12353

State File No. _____
Registrar's No. **3134**

FILED APR 4 1953

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Northwoods	
c. LENGTH OF STAY (If in this place) 2-hrs.		4160	
d. FULL NAME OF HOSPITAL OR INSTITUTION EARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 4000 Colonial Ave.	
3. NAME OF DECEASED a. (First) HATTIE		b. (Middle) Rohrman	
c. (Last) SPENCER		4. DATE OF DEATH (Month) 3 (Day) 23 (Year) 53	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED W.	8. DATE OF BIRTH Nov. 8, 1882
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 4 Days 15	IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Dyer, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME John Rohrman		13b. MOTHER'S MAIDEN NAME Susan Grantges	
14. NAME OF HUSBAND OR WIFE Thomas W. Spencer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Thomas Spencer		ADDRESS 4000 Colonial Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY EDEMA			
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		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 3-23 , 19 53 , to 3-23 , 19 53 , that I last saw the deceased alive on 3-23 , 19 53 , and that death occurred at 3:40 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE F.K. Bradley		23b. ADDRESS BARNES HOSPITAL	
(Degree or title) M.D.		23c. DATE SIGNED 3-23-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Mar. 24, 1953	
24c. NAME OF CEMETERY OR CREMATORY St. Joseph's		24d. LOCATION (City, town, or county) (State) Hamond, Indiana	
DATE REC'D BY LOCAL REG. MAR 23 1953		REGISTRAR'S SIGNATURE J. Carl Smith	
FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		ADDRESS 3840 Lindell Blvd.	

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.