No. 300
10.48

FILED MAY 10 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14636

BIRTH NO. _____ REG. DIST. NO. 337 PRIMARY REG. DIST. NO. 4498 Registrar's No. 31

1020
1

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

1. PLACE OF DEATH
a. COUNTY: SHELBY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): HUNNEWELL
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): TOWN LIMITS

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY: SHELBY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): HUNNEWELL 1020
d. STREET ADDRESS (If rural, give location): TOWN LIMITS

3. NAME OF DECEASED (Type or Print)
a. (First): MATTIE
b. (Middle): —
c. (Last): SPENCER

4. DATE OF DEATH (Month) (Day) (Year): 4-27-1954

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 2/14/1873.
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months 2, Days 13 — IF UNDER 24 HRS.: Hours, Min.

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 (State or foreign country): MISSOURI
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: JOHN SCRATCH
13b. MOTHER'S MAIDEN NAME: ELIZABETH WITHEROP
14. NAME OF HUSBAND OR WIFE: JOHN. E. SPENCER SR. (Dec'd)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: MRS. FRANK LEAKE WHEELING 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 Hemorrage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): High Hand Pressure
DUE TO (c):

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

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 331 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) 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 _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C W Musgrove (Coroner)
23b. ADDRESS: Bethel Mo
23c. DATE SIGNED: 4/27/1954

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 4/30/1954
24c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. CEMETERY
24d. LOCATION (City, town, or county) (State): HUNNEWELL MO

DATE REC'D BY LOCAL REG.: 5-5-54
REGISTRAR'S SIGNATURE: Ada Garrison 4-14-C
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Harold Garner Monroe City

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed.....

Student Embalmer

Signed [illegible]

Licensed Embalmer No. 3720

P. O. Address Monroe City M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.