

FILED SEP 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

 Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 158

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Nevada</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Nevada Hospital</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>123 1/2 E. Walnut</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Almer</u> Middle <u>O.</u> Last <u>Spayd</u>			4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1879</u> <u>January 23</u>
9. AGE (In years last birthday) <u>78</u>		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) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Vernon County, Missouri</u>
13a. FATHER'S NAME <u>Wilson Spayd</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Jackson</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
14. NAME OF HUSBAND OR WIFE -----		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>499-24-4359</u>		17. INFORMANT <u>Wm. A. Spayd</u> Address <u>Kansas City, Missouri</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause, last. DUE TO (b) <u>Hypertensive; arteriosclerotic heart disease</u>			<u>10 years</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4200</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>April 13, 1955</u> to <u>Aug. 17, 1957</u> and last saw ^{her} <u>him</u> alive on <u>August 17, 1957</u> Death occurred at <u>Nevada, Mo.</u> <u>3:45</u> P. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>L. P. McCann, M. D.</u> (Degree or title)		22b. ADDRESS <u>Moore Building, Nevada, Mo.</u>	22c. DATE SIGNED <u>Sept. 3, 1957.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1957</u> <u>August 20</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sandstone Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Vernon County Missouri</u>
24. FUNERAL DIRECTOR <u>Ferry Funeral Home Nevada, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-6-1957</u>	26. REGISTRAR'S SIGNATURE <u>Anna J. Ferry</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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
Signature of Student Embalmer

Signed *L. Stephen Ferry*

Licensed Embalmer No. *4960*

P. O. Address *Newada, T.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.