

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-022560

STATE FILE NUMBER

FILED JUL 3 1958

Registration District No. 200 Primary Registration District No. 4316 Registrar's No. 27

S. 300

1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR PURPLE TYPewriter IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>MACON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>CHARITON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>NEW CAMBRIA</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MARCELINE</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <u>1 hr.</u>	STREET ADDRESS (If outside, give location) <u>0210 RFD 2</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>SPENCER</u> Last <u>SPENCER</u>			4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>58</u>		
5. SEX <u>M</u> <u>O</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/1887</u>	9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR M ^o <u>7</u> D ^y <u>27</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
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>CHARITON Co.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>ARCHIBALD</u>		13b. MOTHER'S MAIDEN NAME <u>SUZANNA KAUP</u>	
14. NAME OF HUSBAND OR WIFE <u>BEULAH SPENCER</u>		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>NONE</u>	
17. INFORMANT Address <u>MRS. BEULAH SPENCER MARCELINE, MO.</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>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4201</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.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u>	STATE <u> </u>
21. I attended the deceased from <u> </u> to <u> </u> and last saw <u>her</u> <u>him</u> alive on <u> </u> Death occurred at <u>1:50</u> <u>P.</u> m on the date stated above; and to the best of my knowledge, from the cause stated.					
22a. SIGNATURE <u>Lester Hutton</u> (Degree or title) <u>Coroner</u>			22b. ADDRESS <u>Macon County, Mo</u>		22c. DATE SIGNED <u>June 20, 58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>R</u>		23b. DATE <u>6/18/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		23d. LOCATION (City, town, or county) (State) <u>MARCELINE, MO</u>
24. FUNERAL DIRECTOR <u>James M. Laughlin</u>		ADDRESS <u>Marceline, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>6/20/58</u>	26. REGISTRAR'S SIGNATURE <u>Thelma M. Neely</u>

COURTESY
Date Filed 7-1-58

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 *James B. McClelland*

Licensed Embalmer No. *4230*

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