

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1959-000030  
STATE FILE NUMBER

FILED FEB 2 1959

Registration District No. 1 Primary Registration District No. 2000 Registrar's No. 38

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>ADAIR</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>CLARK</b> c. CITY OR TOWN <b>6 miles south of Wyaconda</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KIRKSVILLE, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>6 miles south of Wyaconda</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>LAUGHELIN HOSPITAL</b>		Length of stay in lb <b>Weeks</b>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELZA</b> Middle Last <b>SPEER</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>7</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 30, 1891</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>7</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>CLARK COUNTY MO.</b>	
13a. FATHER'S NAME <b>ALBERT SPEER</b>		13b. MOTHER'S MAIDEN NAME <b>EMMERETTA RAINE</b>		14. NAME OF HUSBAND OR WIFE <b>GRACE SPEER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ERMIN SPEER</b> Address <b>WYACONDA, MISSOURI</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MEDULLARY FAILURE</b> DUE TO (b) <b>CONGESTIVE HEART FAILURE AND UREMIA</b> DUE TO (c) <b>TRANSITIONAL CBL CARCINOMA URINARY BLADDER</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>OBSTRUCTION L URETER (Autopsy REFUSED) 1810</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hours</b> <b>2 1/2 weeks</b> <b>UNKNOWN</b>
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 _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <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 <b>Nov 27, 1958</b> to <b>Jan 7, 1959</b> and last saw <sup>her</sup> him alive on <b>JAN 7-1959</b> Death occurred at <b>His P</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Carl Kasper Jr Do 2</b>			22b. ADDRESS <b>Kirksville, Mo</b>		22c. DATE SIGNED <b>1-12-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>JAN. 9, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LIBERTY CEMETERY</b>	
				23d. LOCATION (City, town, or county) (State) <b>5 miles south-east of Wyaconda</b>	
24. FUNERAL DIRECTOR <b>GERTH &amp; BASKETT</b>		ADDRESS <b>WYACONDA, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>1-30-1959</b> 26. REGISTRAR'S SIGNATURE <b>Doris W. Ratliff</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *George V. Bankett* .....

Licensed Embalmer No. *1817* .....  
P. O. Address *Wyacond* .....

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.