RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS AUG 26 1959/60

59-029558
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 3029 Registrar's No. 123

DED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: JEFFERSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: CRYSTAL CITY
Length of stay in 1b:
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: NONE
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JEFF.
c. CITY OR TOWN: CRYSTAL CITY
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 107 OLIVE, ST.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First FRANCES Middle MARIE Last SPENCER

4. DATE OF DEATH: Month 8 Day 18 Year 59

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 12-12-13

9. AGE (last birthday): 45
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HR: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMSTRESS

10b. KIND OF BUSINESS OR INDUSTRY: DEPT. STORE

11. BIRTHPLACE (City and state or country): ST JOSEPH, MO.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: JOHN W. THOMAS

13b. MOTHER'S MAIDEN NAME: FANNY MAE JONES

14. NAME OF HUSBAND OR WIFE: RALPH A.

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: Ralph A. Spencer Address: Crystal City Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 6 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Arterio-sclerosis — Unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 Aug 6th 59 to Aug 18/59 and last saw her/him alive on Aug 18/59
Death occurred at 11:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: J. Cammerford (Degree or title) MD
22b. ADDRESS: Crystal City Mo
22c. DATE SIGNED: 8/20/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 8-24-59
23c. NAME OF CEMETERY OR CREMATORY: ASHLAND CEM.
23d. LOCATION (City, town, or county) (State): ST JOSEPH, MO.

24. FUNERAL DIRECTOR ADDRESS: GENTRY R. POLITTE CRYSTAL CITY, MO.

25. DATE RECD. BY LOCAL REG.: 8-20-59

26. REGISTRAR'S SIGNATURE: [illegible]

(Licensed Embalmer's Statement on Reverse Side)

MAR 1 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Gentry R. Pelit

Licensed Embalmer No. 3481

P. O. Address Crystal Ci

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.