

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 9 5 6

FILED JAN 11 1960

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1394A

RENDERED

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>WEBSTER</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u> Length of stay in 1b <u>26 DAYS</u>		c. CITY OR TOWN <u>MARSHFIELD MO</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 <u>ST JOHNS Hosp.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6 Mi N.W.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>BEN H SPENCER</u>			4. DATE OF DEATH Month Day Year <u>DEC 22 1959</u>			
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11-7-1892</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>SOUTH DAKOTA.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>AMBA SPENCER</u>	13b. MOTHER'S MAIDEN NAME <u>MARTHA MORELAND</u>	14. NAME OF HUSBAND OR WIFE <u>VIOLET</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI</u>	16. SOCIAL SECURITY NO. <u>319-09-5363</u>	17. INFORMANT Address <u>VIOLET SPENCER MARSHFIELD</u>
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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>Arteriosclerotic cerebral thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>uncertain</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Gradual process over several mos (about 6 mo)</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)	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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.)
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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
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21. I attended the deceased from 11-28-59 to Death and last saw him alive on 12-22-59
Death occurred at 3:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Margaret B. Johnson MD</u>	22b. ADDRESS <u>Springfield, Mo.</u>	22c. DATE SIGNED <u>12-31-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12-22-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MARSHFIELD</u>	23d. LOCATION (City, town, or county) (State) <u>MARSHFIELD MO</u>
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24. FUNERAL DIRECTOR ADDRESS <u>BARBER-EDWARDS MARSHFIELD</u>	25. DATE RECD. BY LOCAL REG. <u>Jan 4, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS - JAN 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 me

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

R. W. Bosh

Licensed Embalmer No. 354

P. O. Address W. H. House

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.