

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004801

FILED VS FEB 15 1960 3 F-1

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 4515 Registrar's No. 20

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		c. CITY OR TOWN <u>Milan</u>	
Length of stay in 1b <u>2 months</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sull. Co. M. Hospit</u>		d. STREET ADDRESS (If outside, give location) <u></u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie Octavia Spencer</u>			4. DATE OF DEATH Month Day Year <u>2-9-60</u>		
5. SEX <u>Fm</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>2-28-89</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state of country) <u>Peper - Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>US</u>	

13a. FATHER'S NAME <u>Henry M. Smith</u>		13b. MOTHER'S MAIDEN NAME <u>Emma Myers</u>		14. NAME OF HUSBAND OR WIFE <u>C.E. Spencer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>500-07-9873</u>		17. INFORMANT Address <u>C.E. Spencer Milan 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>Carcinoma of sigmoid colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____		
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.)			
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 checked="" 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 9-1-59 to 2-9-60 and last saw her ^{her} _{him} alive on 2-9-60
 Death occurred at 7:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. Robinson D.D.</u> (Degree or title)	22b. ADDRESS <u>Milan, Mo</u>	22c. DATE SIGNED <u>2-10-60</u>
--	-------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-11-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem</u>	23d. LOCATION (City, town, or county) <u>Milan Mo</u>	(State)
---	--------------------------	---	---	---------

24. FUNERAL DIRECTOR ADDRESS <u>309 E. 11th St. Supt. Schuene Milan Mo</u>	25. DATE RECD. BY LOCAL REG. <u>2-12-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Milan - Ill

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.