

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS MAR 8 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 2071** - **60-008909**

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1518 Mississippi | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Nathan Middle Last Spencer | | | | 4. DATE OF DEATH Month February Day 19 Year 1960 | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 4/10/1901 | 9. AGE (last birthday) 58 | 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) Mail handler | | | 10b. KIND OF BUSINESS OR INDUSTRY Terminal Railroad | | 11. BIRTHPLACE (City and state or country) Calloway Co., Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME Charles Leslie Spencer | | | 13b. MOTHER'S MAIDEN NAME Lula Belle Williams | | | 14. NAME OF HUSBAND OR WIFE Unavailable | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II | | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Mrs. C.L. McAlpin, Mayfield, Ky. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from the wound DUE TO (b) Cirrhosis of the Liver DUE TO (c) Interstitial Nephritis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 977X | | | | | | 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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. PLACE OF INJURY OCCURRED. (For name of injury, see PART I of item 18.) Subdural injury, scalp lacerated cut with razor blade | | | | | | 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year in Home on or about February 19, 1960 |
| 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.) Home | | 20f. CITY, TOWN, OR LOCATION St. Louis Mo | | COUNTY | | STATE |
| 21. I attended the deceased from 8:15 P. to _____ and last saw her alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Frank M. Zeman, Jr. | | | | 22b. ADDRESS 1300 Old | | 22c. DATE SIGNED 2-23-60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 2-23-60 | 23c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery | | 23d. LOCATION (City, town, or county) Mayfield, Ky. | | | (State) |
| 24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. | | | | 25. DATE RECD. BY LOCAL REG. FEB 23 1960 | | 26. REGISTRAR'S SIGNATURE Neal Smith, M.D. M. & B. | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St Louis

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.