

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

FILED VS JUN 9 1960

**=60-021103**

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5590**

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in lb <b>20 yr</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MASONIC HOME HOSPITAL</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5329 Vernon Ave.</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Lillian Spence JAMES</b>				4. DATE OF DEATH <b>5 29 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-13-1870</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (City and state or country) <b>HUNTSVILLE ALABAMA</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>JOHN POTTER SPENCE</b>			13b. MOTHER'S MAIDEN NAME <b>SUE BIFF POLLARD</b>			14. NAME OF HUSBAND OR WIFE <b>WM. HENRY JAMES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Masonic Home of Mo. 5351 Delmar Blvd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>GASTROINTESTINAL HEMORRHAGE</b> IMMEDIATE CAUSE (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) <b>443x</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 HR</b> <b>20 yrs.</b>
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 checked="" 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 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>1955</b> to <b>5-29-60</b> and last saw her/him alive on <b>5-28-60</b> Death occurred at <b>8/10 am</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Harold E. Walters M.D.</b>				22b. ADDRESS <b>3720 Washington St. home</b>		22c. DATE SIGNED <b>5-27-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>5/31/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Missouri</b>			
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>MAY 31 1960</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

701/13

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

*Joseph E. McCullough*

2291

Licensed Embalmer No.

246

123 01/8

P. O. Address

6173 Rd

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.