

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 17 1960

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60-033944

STATE FILE NUMBER

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

DEED

1. PLACE OF DEATH a. COUNTY Buchanan			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b unknown	c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Wilson Nursing Home 611 N. 11th St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 302 N. 20th St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JAMES Middle LAFAYETTE Last SPENCER			4. DATE OF DEATH Month October Day 8 Year 1960		
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/19/1876	9. AGE (last birthday) 83	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer	10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (City and state or country) Buchanan County, Mo.	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME James T. Spencer		13b. MOTHER'S MAIDEN NAME Kate Thomas		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Heaton-Bowman Address Rre-arranged records, St. Joseph, 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) Acute myocardial failure due to					INTERVAL BETWEEN ONSET AND DEATH 1 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary insufficiency Pericardial calcification of pericardium, Bronchitis & Emphysema					?
DUE TO (c) Coronary Sclerosis, Arteriosclerosis gen.					?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. <input checked="" type="checkbox"/> 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____					
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 4-16-52 to 10-8-60 and last saw ^{her} him alive on 9-22-60 Death occurred at 3:20 a. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Wm B. Rasmussen M.D.			22b. ADDRESS 316 N 10th St Joseph Mo		22c. DATE SIGNED 10-10-60
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 10/10/1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Mora Cemetery	23d. LOCATION (City, town, or county) St. Joseph	23e. (State) Missouri	
24. FUNERAL DIRECTOR Heaton-Bowman		ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Oct. 14, 1960	26. REGISTRAR'S SIGNATURE Mrs. Clark Stoddell	

DOCUMENT

W.B. Rasmussen, M.D. 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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Spelling

Licensed Embalmer No. 4535

P. O. Address St. Joseph

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.