

## JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 26 1960

-60-037099

ENDED

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 172

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>4 days</u>		c. CITY OR TOWN <u>Marshall</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>Fitzgibbon hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>469 West Marion</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Samuel</u> Last <u>Alspaw</u>				4. DATE OF DEATH Month <u>September</u> Day <u>17th</u> Year <u>1960</u>											
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>5-12-1880</u>		9. AGE (last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u> Hours <u>    </u> Min. <u>    </u>		IF UNDER 24 HR Hours <u>    </u> Min. <u>    </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>				11. BIRTHPLACE (City and state or country) <u>Saline County Mo.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Jasper Alspaw</u>				13b. MOTHER'S MAIDEN NAME <u>Lillie C. Young</u>				14. NAME OF HUSBAND OR WIFE <u>Laura Ellen Alspaw</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>500-10-7348</u>				17. INFORMANT <u>534 North</u> Address <u>Ellsworth</u> <u>Mrs Charles Tuders, Marshall 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>Cerebral Metastasis from</u> DUE TO (b) <u>Prostatic Carcinoma</u> DUE TO (c) <u>    </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>					
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 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 <u>    </u> a.m. <u>    </u> p.m. <u>    </u>		Month, Day, Year <u>    </u>													
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 <u>JUNE 1960</u> to <u>Sept. 17, 1960</u> and last saw him alive on <u>Sept. 17, 1960</u> . Death occurred at <u>2-55 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <u>Robert W. Alspaw</u>						22b. ADDRESS <u>370 S Odell, Marshall, Mo</u>						22c. DATE SIGNED <u>19 Sept. 1960</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9-20-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Marshall Missouri</u>							
24. FUNERAL DIRECTOR <u>Campbell-Lewis, Marshall Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>9-19-'60</u>				26. REGISTRAR'S SIGNATURE <u>Carl G. Lead</u>							

DOCUMENT

MEDICAL CERTIFICATION

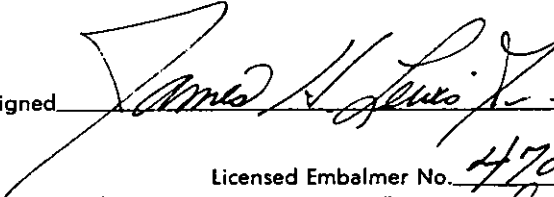
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. 452 working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed



Licensed Embalmer No. 4709

P. O. Address Marshall

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.