

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045232

FILED VS DEC 19 1960 042

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 1284

STATE FILE NUMBER

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 lb 30 Yrs		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 1710 Seneca St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1710 Seneca St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MIDDLE LAST AUBREY JAMES SPANGLER				4. DATE OF DEATH Month Day Year December 9, 1960					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 8-6-1914	9. AGE (last birthday) 46	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) Cook			10b. KIND OF BUSINESS OR INDUSTRY Cafe		11. BIRTHPLACE (City and state or country) Guilford, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME John N. Spangler			13b. MOTHER'S MAIDEN NAME Mary J. Farris			14. NAME OF HUSBAND OR WIFE Mary Catherine Spangler			
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. 491-09-3022		17. INFORMANT Marcy C. Spangler			Address 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) <u>Metastatic Carcinoma</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchial Carcinoma</u> 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							INTERVAL BETWEEN ONSET AND DEATH Unk. Unk.		
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 <u>7/26/60</u> to <u>12/9/60</u> and last saw ^{her} him alive on <u>12/8/60</u> Death occurred at <u>12:05</u> a <u>a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>S.E. Meluney M.D.</u>				22b. ADDRESS <u>Social Welfare Board 10th & Olive, St. Joseph, Mo.</u>				22c. DATE SIGNED <u>12/9/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 12, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>			
24. FUNERAL DIRECTOR <u>H.O. Sidenfaden & Son</u> <u>APM</u>			ADDRESS <u>St Joseph, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Dec. 12, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Stoddell</u>		

DOCUMENT

S.E. Meluney M.D. Medical Certification

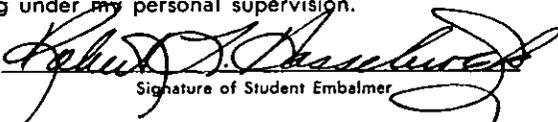
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

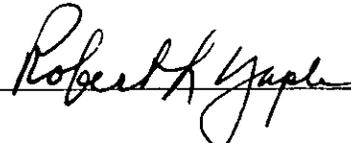
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by Robert L. Hassebroek, Student Embalmer No. 617

working under my personal supervision.

Student


Signature of Student Embalmer

Signed



Licensed Embalmer No. X 3308

P. O. Address St. Joseph, Mo.

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.