

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-047066

FILED VS. DEC 29 1960

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 250

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		Length of stay in 1b <u>3 Days</u>		c. CITY OR TOWN <u>Cuba,</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>Phelps Co. Mem. Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>704 East Washington</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>C.</u> Last <u>SPENCER</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</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>8-3-1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>11</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>Building Contractor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (City and state or country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James J. Spencer</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Walls</u>			14. NAME OF HUSBAND OR WIFE <u>Florence (Lona) Farway</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>498-05-5125</u>		17. INFORMANT <u>Mrs. LENA Spencer, Cuba, 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>Degenerative heart disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>also had prostatic hypertrophy - surgery 12/14/60</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Heart & hypertrophic arthritis, severe</u> 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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u></u>				
20c. TIME OF INJURY Hour <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.) <u></u>		20f. CITY, TOWN, OR LOCATION <u></u>		COUNTY <u></u>		STATE <u></u>		
21. I attended the deceased from <u>Jan 1940</u> to <u>12-14-60</u> and last saw him alive on <u>12-14-60</u> Death occurred at <u>2:05 AM 12-15-60</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>[Signature]</u> (Degree & title)				22b. ADDRESS <u>St James mo</u>		22c. DATE SIGNED <u>12/15/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-17-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Heming Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cuba Crawford, Missouri</u>				
24. FUNERAL DIRECTOR'S ADDRESS <u>[Signature], Cuba, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Dec. 17, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Nadene S. Stoll</u>			

DOCUMENT

MEDICAL CERTIFICATION

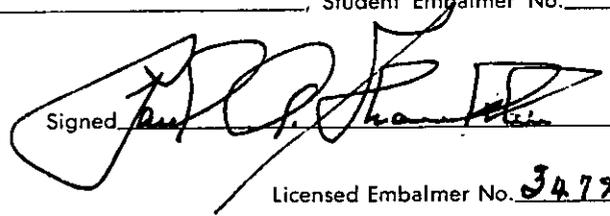
BY AFFIDAVIT OF

DEC 29 1960

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 3472

P. O. Address Cuba, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.