

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-025646

AMENDED

Registration District No. 150

Primary Registration District No. 5573

Registrar's No. 59

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sni A Bar TWP Length of stay in 1b 2yrs

c. CITY OR TOWN Oak Grove Inside Limits Yes No

c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION Buckner-Tarsney Rd Inside Limits Yes No

d. STREET ADDRESS (If outside, give location) Buckner Tarsney Rd Reside on Farm Yes No

3. NAME OF DECEASED First Arthur Middle C Last Spencer

4. DATE OF DEATH Month July Day 13 Year 1961

5. SEX Male

6. COLOR OR RACE Wh

7. Married Never Married Widowed Divorced

8. DATE OF BIRTH 8/9/1887

9. AGE (last birthday) 74 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engenere

10b. KIND OF BUSINESS OR INDUSTRY Gen Mills

11. BIRTHPLACE (City and state or country) Ontario Canada

12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Robert Spencer

13b. MOTHER'S MAIDEN NAME Minnie Pringle

14. NAME OF HUSBAND OR WIFE Mary M Spencer

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. _____

17. INFORMANT Mary Spencer Address Oak Grove Mo R.F.D

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 15 min.
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

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 1/1/60 to 7/13/61 and last saw him alive on 7/13/61
Death occurred at 2:45 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) M.D.

22b. ADDRESS 808 So 15 Blue Springs Mo

22c. DATE SIGNED 7/14/61

23a. BURIAL, CREMATION, REMOVAL, SPECIFIC Burial

23b. DATE 7/15/1961

23c. NAME OF CEMETERY OR CREMATORY Koger Cem

23d. LOCATION (City, town, or county) (State) R.F.D Oak Grove Mo

24. FUNERAL DIRECTOR Webb Funeral Home Blue Springs Mo ADDRESS _____

25. DATE RECD. BY LOCAL REG. 7-15-61

26. REGISTRAR'S SIGNATURE [Signature]

JUL 24 1961

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Frost

Licensed Embalmer No. 4733

P. O. Address Blue Springs

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.