

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-034968
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8875

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>	Length of stay in 1b <u>4 1/2 YRS</u>	c. CITY OR TOWN <u>St. Louis</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>Homer G. Phillips</u>		d. STREET ADDRESS (If outside, give location) <u>1322 N Euclid</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle Last <u>Spencer</u>	4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>61</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-1908</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PORTER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>WAGNE ELECTRIC</u>	11. BIRTHPLACE (City and state or country) <u>Memphis TENN</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
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13a. FATHER'S NAME <u>ALVIN SPENCER</u>	13b. MOTHER'S MAIDEN NAME <u>ESTELLA BUSH</u>	14. NAME OF HUSBAND OR WIFE <u>HELEN SPENCER</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>	17. INFORMANT <u>MARION SCOTT 4220 E. COTE BRILLIANT</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>		<u>Undet.</u>
DUE TO (b) <u>Arteriosclerosis</u>		<u>Undet.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>332x</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</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
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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.)
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20c. TIME OF INJURY Hour <u>11:00</u> Month, Day, Year <u>9-14-61</u> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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 <u>St. Louis</u> COUNTY STATE
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21. I attended the deceased from <u>9-14-61</u> to <u>9-22-61</u> and last saw him alive on <u>9-22-61</u> Death occurred at <u>11:00</u> <u>P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Sydney A. Frazer, M.D.</u>	22b. ADDRESS <u>2601 N. Whittier Street</u>	22c. DATE SIGNED <u>9-23-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-27-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST LOUIS 22 MO</u>
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24. FUNERAL DIRECTOR <u>PRICE UND. CO INC. 2829 WASHINGTON</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 25 1961</u>	26. REGISTRAR'S SIGNATURE <u>Rosal Smith, M.D.</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 SHOULD READ
 ITEM NO.
 BY AFFIDAVIT OF

DOCUMENT
MEDICAL CERTIFICATION

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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney

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.