

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-031470

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 407

FILED SEP 5 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

17005

20542

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DATE AMENDED
9/18/62 9/18/62

INSTEAD OF
490-48-8784

SHOULD READ
480-12-9987

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Laffayette	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 1 Yr.	c. CITY OR TOWN Lexington Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep. San. And Hosp.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Lexington Mo. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) CARL L. SPENCER			4. DATE OF DEATH Month Aug. Day 24 Year 1962
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 Aug. 9, 1921
9. AGE (last birthday) 41		IF UNDER 1 YEAR Months 41 Days 0 Hours 0 Min. 0	IF UNDER 24 HR Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest		10b. KIND OF BUSINESS OR INDUSTRY Bendix	11. BIRTHPLACE (City and state or country) Waverly Mo.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Geo. Spencer 13b. MOTHER'S MAIDEN NAME Marie Gadde 14. NAME OF HUSBAND OR WIFE Mrs. Elizabeth Spencer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW2		17. INFORMANT Address Mrs. Elizabeth Spencer Lexington 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) Stroke - Hemorrhage, resulting from crushing injury of chest with multiple rib fractures, laceration of lung & fracture of cervical vertebrae.			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Crushing injury of chest with multiple rib fractures, laceration of lung & fracture of cervical vertebrae. DUE TO (c) Crushing injury of chest with multiple rib fractures, laceration of lung & fracture of cervical vertebrae.			
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 checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) One car collision, car	
20c. TIME OF INJURY Hour 8:24 Month, Day, Year 62	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> slush bucket contact		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway	20f. CITY, TOWN, OR LOCATION Jackson	COUNTY Mo	STATE Mo
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____. Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Geo. C. Carson		22b. ADDRESS 6627 Parkside Dr	22c. DATE SIGNED 8-25-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-25-62	23c. NAME OF CEMETERY OR CREMATORY Lexington Cemetery	23d. LOCATION (City, town, or county) (State) Lexington Mo.
24. FUNERAL DIRECTOR ADDRESS Geo. C. Carson and Sons Indep. Mo.		25. DATE RECD. BY LOCAL REG. 8-25-62	26. REGISTRAR'S SIGNATURE Alba L. Craig

USE BLACK INK OR TYPEWRITER RIBBON

SEP 6 1962

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 Charles J. Tyb

Licensed Embalmer No. 4534

P. O. Address Spentwood

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.