N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

12619

File No. 1550

Registered No. 1550

1. PLACE OF DEATH

County JACKSON Registration District No. 399

Township KAW Primary Registration District No. 1002

City KANSAS CITY (No. SAVOY HOTEL (9TH + CENTRAL St.) Ward)

2. FULL NAME SPENCER A ALEXANDER

(a) Residence, No. 5710 CENTRAL St., 8 Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR ~~WIFE OF~~) MRS. HERMA ALEXANDER

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 30 1893

7. AGE: YEARS 38 | MONTHS 5 | DAYS 12 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. OFFICE MANAGER 141

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. GUARDIAN LIFE INSURANCE CO.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation 1 - MONTH

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ~~UNKNOWN~~ Hale Mo

FATHER

13. NAME Wm. T. Alexander

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

MOTHER

15. MAIDEN NAME Elizabeth Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

17. INFORMANT MRS. HERMA ALEXANDER
(ADDRESS) 5710 CENTRAL ST.

18. BURIAL, CREMATION, OR REMOVAL
PLACE FOREST HILL DATE APRIL-14 1932

19. UNDERTAKER D. W. NEWCOMER'S SONS
(ADDRESS) KANSAS CITY, MISSOURI

20. FILED 4-13- 1932 M. M. Grove
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) APRIL-12 1932

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at .....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lancinating Pain	
167	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19 32

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Lancinating Pain

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) ....., M. D.

(Address)