

Registration District No. 106 45 1940

Primary Registration District No. 43058

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town New Madrid  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: No  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution No (Specify whether  
In this community About 104 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town New Madrid  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME MARTBY SPENCER 152

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife JOE SPENCER 6. (c) Age of husband or wife if alive No years

7. Birth date of deceased about 18 26  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
About 104 hr. \_\_\_\_\_ min.

9. Birthplace New Madrid, Co.  
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business No

12. Name (unk) Gay

13. Birthplace Ohio Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name No

15. Birthplace No No  
(City, town, or county) (State or foreign country)

16. (a) Informant A. D. Shaw

(b) Address Wardell

17. (a) Burial (b) Date thereof JUNE 18-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wardell

18. (a) Signature of funeral director Richards Ind Co.

(b) Address New Madrid, Mo.

19. (a) 6/18/1940 (b) Wm O'Bannon  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17  
year 1940 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death NO MEDICAL ATTENTION - FROM RECORD SEXILITY  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_ 16 72

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

533 (Specify type of place) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature J. Whitehead Jr coroner's (M. D. or other) \_\_\_\_\_

Address New Madrid, Mo Date signed 6-18-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2  
7  
0

RECEIVED

District Health Officer No. 2,

District File Number

640-1164

Date Filed

6/29-40

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

Registered Apprentice No.

working under my personal supervision.

Signed

Licensed Embalmer No.

P.O. Address

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 this body is not embalmed, above space should be left blank.