

1. PLACE OF DEATH:
 (a) County Dade Co. Mo.
 (b) City or town Lockwood
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution my
 In this community Most of his life
 years, months or days

3. (a) PRINT FULL NAME James E. Speer
 3. (b) If veteran, name war no (c) Social Security No. _____

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Mary Speer 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased August 8 1860
 (Month) (Day) (Year)

8. AGE: Years 81 Months 11 Days 9 If less than one day
 hr. _____ min. _____

9. Birthplace Dade Co. Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Minister

11. Industry or business _____

12. Name Hogan Speer
 13. Birthplace Jennett
 (City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Kenyon
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Laura Bartlett
 (b) Address Golden City Mo.

17. (a) Burial (b) Date thereof Dec 19 1941
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetary Mo.

18. (a) Signature of funeral director Ray Caldwell
 (b) Address Lockwood Mo.

19. (a) 12-24-41 (b) J. B. Whren
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Dade
 (c) City or town Lockwood
 (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.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 17
 year 1941 hour 1:00 minute _____ P. M.

21. I hereby certify that I attended the deceased from 12-3-
 1941 to 12-16 1941;
 that I last saw him alive on 12-16- 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Malignancy of face + neck.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 53

Major findings: Of operations _____
 Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. D. Combs (M. D. or other) _____
 Address 12-19-41 Date signed 12-19-41

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 142-108

Date Filed JAN 13 1942

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.....

.....
working under my personal supervision.

Registered Apprentice No.

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, fact should be so stated above.