p. 2
4-41
17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 22 1942

Registration District No. 26

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3002

State File No. 10060

Registrar's No. 41

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

4
1
2

1. PLACE OF DEATH:
(a) County: AUDRAIN
(b) City or town: MEXICO City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: AUDRAIN COUNTY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 0 (Specify whether
In this community: 3 DAYS
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 004
(a) State: MISSOURI (b) County: AUDRAIN
(c) City or town: VANDALIA
(If outside city or town limits, write "RURAL")
(d) Street No. 614 WEST UNION
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: SARAH BELLE Spencer
3. (b) If veteran, name war:
3. (c) Social Security No. NONE
4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: WILLIAM SPENCER
6. (c) Age of husband or wife if alive: 79 years
7. Birth date of deceased: JULY (Month) 13 (Day) 1871 (Year)

8. AGE: Years 70 Months 8 Days 4 If less than one day hr. min.

9. Birthplace: PIKE COUNTY (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation: HOUSEWIFE
11. Industry or business:
FATHER 12. Name: GEORE FRANKUM
13. Birthplace: (City, town, or county) INDIANA ! (State or foreign country)
MOTHER 14. Maiden name: BARBARA JONES
15. Birthplace: (City, town, or county) INDIANA ! (State or foreign country)
16. (a) Informant: MYRTLE SCHULZE
(b) Address: VANDALIA MISSOURI
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: MAR 17 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: VANDALIA, MO
18. (a) Signature of funeral director: W. S. Waters
(b) Address: Vandalia, Missouri
19. (a) Mar-16-1942 (Date received local registrar) (b) Margaret H Mackie (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17
year 1942 hour 6:00 minute 45 A. M.
21. I hereby certify that I attended the deceased from March 15 1942 to March 17 1942
that I last saw her alive on March 16 1942
and that death occurred on the date and hour stated above.

Immediate cause of death: Perix of Stomach ruptured — Duration
Due to: Hypertension
Due to: —
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operation: No operation
Of autopsy: None

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): no
(b) Date of occurrence: no
(c) Where did injury occur? no (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: — 0
23. Signature: H C Brashear (M. D. or other) MD
Address: Mexico, Mo Date signed 3/17/42

1074 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 4-16-855
Date Filed APR 16 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 .....

....., Registered Apprentice No. .....

working under my personal supervision.

Signed Wm B Waters

Licensed Embalmer No. 4169

P. O. Address Vandalia, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
M—8-21-41
T X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10060

Registration District No. 26 Primary Registration District No. 3002 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Audrain
(b) City or town Mexico
(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 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Sarah B. Spencer
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 13 (Day) 1871 (Year)
8. AGE: Years 70 Months 8 Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar Day 17 year 1942 hour minute 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.

	Duration
Immediate cause of death Varix of stomach, ruptured	
Due to: No history to substantiate a diagnosis of either	
Due to: malignancy or tuberculosis	
Other conditions condition of patient so extreme that diagnostic	
(Include pregnancy within 3 months of death) procedure could not be	
Major findings instituted.	
Contributory conditions	
Of autopsy H C Brashear	

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) 118.1
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY