

FILED SEP 29 1943

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 121

Primary Registration District No. 4200

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Ash Grove
(c) Name of hospital or institution: Residence
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) Scraperh years

3. (a) PRINT FULL NAME Walter Fay Spence

3. (b) If veteran, name war World War #1 3. (c) Social Security No. ✓

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Feark Spence 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 2 - 28 - 1892
(Month) (Day) (Year)

8. AGE: Years 51 Months 6 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace St. Anthony Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business _____

MOTHER, FATHER { 12. Name UNKNOWN
13. Birthplace UNKNOWN
14. Maiden name Rosa Longest
15. Birthplace UNKNOWN

16. (a) Informant Mrs. Feark Spence

(b) Address Ash Grove Mo.

17. (a) Burial (b) Date thereof 9-12-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ponnsboro

18. (a) Signature of funeral director Morgan Simon

(b) Address ash Grove

19. (a) 9-13-43 (b) W. Burch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Ash Grove
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) _____
(e) Citizen of foreign country? ✓ (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 10 year 1943 hour 3 minute 40 P. M.

21. I hereby certify that I attended the deceased from for the past 4 or 5 years 1943 to Sept 10 1943 that I last saw him alive on Sept 10 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis

Due to HYPERTENSION & Renal Disease

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations no Of autopsy none held

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? _____

23. Signature Charles H. McHaffie (M. D.) Mo. D.
Address Ash Grove, Mo. Date signed 9-13-43

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

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6

RECEIVED

Greene County Health Office,

County File

Number

43-9-96

Date Filed

2/28/95

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

J. R. Leman

Licensed Embalmer No. 3297

P. O. Address

Miller Mo.

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.