

FILED APR 17 1947

Registration District No. **30**

Primary Registration District No. **6033**

Registrar's No. **2202**

1. PLACE OF DEATH:

(a) County **Ripley**  
 (b) City or town **Rural**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**18 mi. S.W. of Doniphan**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community **70 years**  
 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Ripley** **91**  
 (c) City or town **Rural** **0**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **18 mi. S.W. of Doniphan** **0**  
 (If rural, give location) **0**  
 (e) Citizen of foreign country? **-No-** (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **William Amos Spencer**

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

4. Sex **Male** 5. Color or race **White**  
 6. (a) Single, widowed, married, divorced, **widower**  
 6. (b) Name of husband or wife **Lucy Spencer (deceased)** 6. (c) Age of husband or wife if \_\_\_\_\_ years  
 7. Birth date of deceased **Sept. 28, 1865**  
 (Month) (Day) (Year)

8. AGE: Years **81** Months **5** Days **21** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Tennessee**  
 (City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name **Tom Spencer** **9**  
 13. Birthplace **Unknown** **9**  
 (City, town, or county) (State or foreign country)  
 14. Maiden name **Unknown**  
 15. Birthplace **Unknown** **9**  
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Bertie Phillips**  
 (b) Address **Poynor, Mo.**

17. (a) **Burial** (b) Date thereof **3/23/47**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **Poynor, Mo.**

18. (a) Signature of funeral director **Black-Edwards**  
 (b) Address **Doniphan, Mo.**

19. (a) **3-21-47** (b) **[Signature]**  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **19**  
 year **1947** hour **9** minute **9** A.M.  
 21. I hereby certify that I attended the deceased from **3**  
**March** 19**47**, to **19 March** 19**47**.  
 That I last saw him alive on **15 March** 19**47**,  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Embolus**  
 Duration \_\_\_\_\_  
 Due to **Recovering from Pneumonia**  
 Due to \_\_\_\_\_

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

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury **0**

23. Signature **J. E. Williams** (M. D. or other) \_\_\_\_\_  
 Address **Doniphan** Date signed **3-21-47**

RECEIVED

District Health Officer No. 5,

District File Number 4 4720/

Date Filed 4-15-47

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 L. Poljeau Adamson

Licensed Embalmer No. 4351

P. O. Address Doriphan, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. May  
Registrar's No. 2202

Registration District No. 301

Primary Registration District No. 6033

1. PLACE OF DEATH:

(a) County Ripley  
(b) City or town Rural  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Wm A. Spencer

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased Sept 28 1886  
(Month) (Day) (Year)

8. AGE: Years 81 Months 5 Days \_\_\_\_\_ (if less than one day) \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Tenn

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

15. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec 19 19  
year 194 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death: Pneumonia  
hatched

Duration

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

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

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? \_\_\_\_\_

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

23. Signature J. H. ... (M. D. or other) \_\_\_\_\_

Address Amphian Mo Date signed 5-8-47

SUPPLEMENTARY

14711