

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

33352

State File No.

FILED OCT 11 1947

Registrar's No. 2044

Registration District No. 377

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County: St. Louis
(b) City or town: Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 569 days
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: oaw
(c) City or town: St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No.: 4206 West Page
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Spencer, Robert Lee

3. (b) If veteran, name war: 3. (c) Social Security No. 497-10-2399

4. Sex: Male 5. Color or race: Negro 6. (a) Single, widowed, married, divorced: Divorced

6. (b) Name of husband or wife: 6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: March 8 1916
(Month) (Day) (Year)

8. AGE: Years: 31 Months: 6 Days: 20 If less than one day: hr. min.

9. Birthplace: St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation: Food Handler

11. Industry or business:

12. Name: Oscar Spencer

13. Birthplace: Chicago Illinois
(City, town, or county) (State or foreign country)

14. Maiden name: Alice Floyd

15. Birthplace: (?) California
(City, town, or county) (State or foreign country)

16. (a) Informant: Hospital Records
(b) Address: Robert Koch Hospital

17. (a) (b) Date thereof: 1-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Greenwood

18. (a) Signature of funeral director: A. F. Walter
(b) Address: 2797 S. Grand Ave. St. Louis

19. (a) 10-27-47 (b) MS
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: September Day: 28
year: 1947 hour: 6 minute: 45 A.M.

21. I hereby certify that I attended the deceased from: 3-8-46 to 9-28-47
that I last saw him alive on 9-28-47
and that death occurred on the date and hour stated above. Duration

Immediate cause of death: Pulmonary Tuberculosis 6 yrs. (?)

Due to:

Due to: 136

Other conditions: Tuberculous Epididymitis;
(Include pregnancy within 3 months of death)

Major findings: Tbc. of Seminal Vesicle

Of operations: Of autopsy: Confirmed above

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? (Specify type of place)

While at work? (c) Means of injury: 0

23. Signature: Bernard Friedman (M. D. or other) M.D.

Address: Robert Koch Hospital Date signed: 9-29-47

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

MOTHER FATHER

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.....

Arthur L. Hilliard

Licensed Embalmer No. *4221*

P. O. Address *1154 Bayanla*

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.