

Registration District No. 28

Primary Registration District No. 2000

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Veterans Administration Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 mo. 5 days
(Specify whether years, months or days)

In this community since hospitalized

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

(c) City or town Carterville
(If outside city or town limits, write "RURAL")

(d) Street No. 422 North Fountain
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3: (a) PRINT FULL NAME SPENCER, Bonnie A.

3. (b) If veteran, name war WW One

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 Marie Spencer

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased 5-30-1897
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>50</u>	<u>10</u>	<u>20</u>	hr. _____ min. _____

9. Birthplace Chicopee, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business _____

MOTHER FATHER { 12. Name Charley Spencer

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Osha Cockran

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record

(b) Address VAH, Springfield, Missouri

17. (a) Removal (b) Date thereof 4/19/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oronogo Cem.

18. (a) Signature of funeral director Hedge Funeral Home

(b) Address Webb City, Mo.

19. (a) 6/5/48 (b) W. J. Bondurant M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19
year 1948 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from 7-15-47
19____, to 4-19-48, 19____;
that I last saw him alive on 4-19-48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute congestive heart failure.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) 93E

Major findings:
Of operations _____

Of autopsy _____

Duration _____

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)

W. J. Bondurant M.D.
Clinical Director (M. D. or other) _____

Address VAH, Springfield, Mo. Date signed 6-7-48

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

4
2
6

49
4
0
1

JUN 28 1948



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 Richard Gray Lewis
Licensed Embalmer (No. 4403)
P. O. Address Webb City 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.