

THE DIVISION OF HEALTH OF MISSOURI
FILED JUL 29 1950 ✓ **STANDARD CERTIFICATE OF DEATH**

25300

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6232**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5803 Theodosia Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5803 Theodosia Ave.,			
3. NAME OF DECEASED a. (First) Melissa b. (Middle) Ann c. (Last) Spencer			4. DATE OF DEATH (Month) (Day) (Year) July 20, 1950
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 10, 1880
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 5 Days 10	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) 9
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Robert Warren		13b. MOTHER'S MAIDEN NAME Melinda Harris	14. NAME OF HUSBAND OR WIFE John Spencer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME John Spencer ADDRESS 5803 Theodosia

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric Carcinoma		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 151X

22. I hereby certify that I attended the deceased from **July 4, 1950**, to **July 19, 1950**, that I last saw the deceased alive on **July 19, 1950**, and that death occurred at **9:00A m.**, from the causes and on the date stated above.

23a. SIGNATURE R. N. Grod (Degree or title) D.O.	23b. ADDRESS 8367 Olive St. Rd.	23c. DATE SIGNED 7/20/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jul 20 1950	24c. NAME OF CEMETERY OR CREMATORY St. Mary's	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. JUL 20 1950	REGISTRAR'S SIGNATURE J. B. Casper	25. FUNERAL DIRECTOR'S SIGNATURE W. H. ... ADDRESS ...
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Clement McNear

Licensed Embalmer No. 3732

P. O. Address St Louis

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.