

FILED FEB 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8898

BIRTH NO. _____		REG. DIST. NO. <u>42</u>		PRIMARY REG. DIST. NO. <u>1000</u>		Registrar's No. <u>193</u>	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>14 1/2 - 4 mo 16 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Joseph</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital no 2</u>				d. STREET ADDRESS (If rural, give location) <u>518 Mitchell Ave</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Clay</u>		b. (Middle)		c. (Last) <u>Spencer M. D.</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 19 1951</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	
8. DATE OF BIRTH <u>Sept. 15, 1879</u>		9. AGE (in years last birthday) <u>71</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u>		IF UNDER 1 YEAR Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>m. D.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physician</u>		11. BIRTHPLACE (State or foreign country) <u>Platte County Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13a. FATHER'S NAME <u>W. N. Spencer</u>		13b. MOTHER'S MAIDEN NAME <u>Eliza Ann Martin</u>		14. NAME OF HUSBAND OR WIFE <u>✓</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes World War I</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Charles W. Spencer</u>		ADDRESS <u>Delath Mo</u>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Lobar Pneumonia</u> DUE TO (c) <u>Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 day</u> <u>49:28</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?			
22. I hereby certify that I attended the deceased from <u>Feb 11</u> , 19 <u>51</u> , to <u>Feb 19</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>51</u> , and that death occurred at <u>1:45</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Forrest Thomas M. D.</u>				23b. ADDRESS <u>St. Joseph Mo 17 State Hosp no 2</u>		23c. DATE SIGNED <u>2/19-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/20/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Heaton Cemetery De Kalb</u>		24d. LOCATION (City, town, or county) (State) <u>Missouri</u>	
DATE REC'D BY LOCAL REG. <u>Feb 23, 1951</u>		REGISTRAR'S SIGNATURE <u>Carl E. Cast</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Heaton-Bowman Funeral Home</u>		ADDRESS <u>St Joseph, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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.....

working under my personal supervision.

Student Embalmer No.....

Signed *William Spalding*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *4535*

P. O. Address *319 S. 11th St. Des Moines, Ia*

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.