

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **8590**
1331

FILED APR 5 1952

BIRTH NO. **14994**REG. DIST. NO. **149**PRIMARY REG. DIST. NO. **1002** Registrar's No.

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

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. LENGTH OF STAY (In this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City		3278 3270
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital No. 1			d. STREET ADDRESS (If rural, give location) 1409 Cherry		
3. NAME OF DECEASED (Type or Print) Fred Eugene			a. (First)	b. (Middle)	c. (Last) Spencer
4. DATE OF DEATH 3 19 52		4. DATE OF DEATH (Month) (Day) (Year)	5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Mar. 2 1952		9. AGE (In years last birthday) 17	IF UNDER 1 YEAR Months 17 Days	IF UNDER 1 YEAR Months 17 Days	IF UNDER 1 HR. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas City, Mo.	
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME Fred Spencer		
13b. MOTHER'S MAIDEN NAME Mollie Belle Riley			14. NAME OF HUSBAND OR WIFE —		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Fred Spencer	
17. ADDRESS Kas. City, Mo.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dehydration and acidosis			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Infantile diarrhea		DUE TO (c) Undetermined cause	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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)		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 Mar. 2 , 19 52 , to Mar. 19 , 19 52 , that I last saw the deceased alive on Mar. 19 , 19 52 and that death occurred at 11:05 P.M. , from the causes and on the date stated above.					
23a. SIGNATURE B. I. Burns (Degree or title)			23b. ADDRESS 24th & Cherry		23c. DATE SIGNED 3-20-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Mar 21 1952	24c. NAME OF CEMETERY OR CREMATORY Green Lawn Cem		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
DATE REC'D BY LOCAL REG. 3-21-52		REGISTRAR'S SIGNATURE Heraldine Holmes		25. FUNERAL DIRECTOR'S SIGNATURE Mrs C.L. Forster	
				ADDRESS 918 Brooklyn K.C. Mo.	

Dr. J. J. J. J.

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 *Dean Ouent*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *4280*.....

P. O. Address *1500 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.