

FILED APR 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11597**

BIRTH NO. _____		REG. DIST. NO. 93		PRIMARY REG. DIST. NO. 5333		Registrar's No. 54-29	
1. PLACE OF DEATH a. COUNTY Dade				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Dade			
b. CITY OR TOWN Lockwood R.H. 2472		c. LENGTH OF STAY (in this place) None		c. CITY OR TOWN Lockwood		d. STREET ADDRESS (If rural, give location) R.F.D. 0290	
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence				d. STREET ADDRESS (If rural, give location) R.F.D. 0			
3. NAME OF DECEASED (Type or Print) a. (First) Ind b. (Middle) E. c. (Last) SPENCER			4. DATE OF DEATH (Month) (Day) (Year) 4-10-1954				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH (Specify) 11-15-1883		9. AGE (in years last birthday) 70	IF UNDER 1 YEAR Months 4 Days 26	IF UNDER 12 mos. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (City and State or Foreign Country) Lawrence Co.		12. CITIZEN OF WHAT COUNTRY? Native	
13a. FATHER'S NAME William Spencer			13b. MOTHER'S MAIDEN NAME Nancy Webb		14. NAME OF HUSBAND OR WIFE Leon Spencer		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Leon Spencer			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Failure					INTERVAL BETWEEN ONSET AND DEATH
		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 (a.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		7824	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from after death , 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:30 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE W.R. Allison			23b. ADDRESS Greenfield Mo			23c. DATE SIGNED 4-10-54	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4-10-1954	24c. NAME OF CEMETERY OR CREMATORY Red Oak		24d. LOCATION (City, town, or county) (State) N.W. of Miller Mo.		
DATE REC'D BY LOCAL REG. 4-12-54		REGISTRAR'S SIGNATURE J. C. Canada		25. FUNERAL DIRECTOR'S SIGNATURE Morris Seiman			
				ADDRESS Miller Mo			

(Licensed Embalmer's Statement (on Reverse Side))

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 *E. H. Lemar*

Licensed Embalmer No. 3297

P. O. Address Miller Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.