

NOV 19 1958 Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 378

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Hannibal
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Levering Hospital		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 064 1603 Broadway
3. NAME OF DECEASED (Type or print) First Middle Last James Edward Spencer			4. DATE OF DEATH Month Day Year 11/4/1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe worker-Retired		10b. KIND OF BUSINESS OR INDUSTRY Bluff City	11. BIRTHPLACE (City and state or country) Vandalia, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Porter Spencer	
13b. MOTHER'S MAIDEN NAME Susan		14. NAME OF HUSBAND OR WIFE Anna May Spencer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna May Spencer		Address 1603 Broadway	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma DUE TO (b) Coronary Heart Disease DUE TO (c) Cardiac Decompensation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 wks. 2021
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 9-7-58 to 11-4-58 and last saw her alive on 11-4-58 Death occurred at 12:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE A.J. Roller, M.D.		22b. ADDRESS 228 Broadway, Hannibal, Mo.	
22c. DATE SIGNED 11/14/58			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
Burial		11/6/58	
23c. NAME OF CEMETERY OR CREMATORY Grange View Burial Park		23d. LOCATION (City, town, or county) (State) Hannibal, Mo.	
24. FUNERAL DIRECTOR H.M.O'Donnell, Hannibal, Mo.		25. DATE RECD. BY LOCAL REG. 11-17-1958	
26. REGISTRAR'S SIGNATURE Dr. E. M. Luckey & C. Fisher			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

RECEIVED NOV 18 1958

MARION CO. HEALTH DEPT.

DATE FILED NOV 18 1958

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
Signature of Student Embalmer

Signed *A. M. O'Donnell*

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.