

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005290

STATE FILE NUMBER

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 19

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Bethany</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Bethany</u> c 416 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Yoll Hosp.</u>		Length of stay in lb <u>1 hr.</u>	d. STREET ADDRESS (If outside, give location) <u>2319 Newburn</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Versailles</u> Last <u>Spence</u>			4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>3</u> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1906</u>	9. AGE (In years, last birthday) <u>52</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>15</u> Hours <u>    </u> Min. <u>    </u>	IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>    </u>	11. BIRTHPLACE (City and state or country) <u>Harrison County Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Roy Spence</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Mills</u>	14. NAME OF HUSBAND OR WIFE <u>Divorced</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, to what service) (If yes, give dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>48603-7431</u>	17. INFORMANT <u>Kathleen Van Hoozer</u> Address <u>Marionville Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>CHRONIC CONGESTIVE HEART FAILURE</u>	<u>1 year</u>
	DUE TO (c) <u>HYPERTENSIVE HEART DISEASE</u>	<u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>44.3X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>7</u>

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.)
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20c. TIME OF INJURY Hour <u>    </u> Month, Day, Year a.m. <u>    </u> p.m. <u>    </u>	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 <u>Bethany Mo.</u>	COUNTY <u>    </u>	STATE <u>    </u>
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21. I attended the deceased from <u>10-23-58</u> to <u>2-24-59</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>2-24-59</u> Death occurred at <u>10:35 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Albert Tribbe</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>Bethany Mo.</u>	22c. DATE SIGNED <u>2-25-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-26-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Missouri</u>	23d. LOCATION (City, town, or county) <u>Bethany Mo.</u> (State)
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24. FUNERAL DIRECTOR <u>W. H. Haas</u> ADDRESS <u>Bethany Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>2-26-1959</u>	26. REGISTRAR'S SIGNATURE <u>Gella Mays</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57

All diseases in Part I must be causally related.

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 *MBS/Jan* .....

Licensed Embalmer No. *3899* .....  
P. O. Address *Bethany, 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.