

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-035002  
4632 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4632

FILED SEP 24 1962

VS 300  
Rev. 4/59

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DATE AMENDED 9-11-62

INSTEAD OF Edna Mae Phelps

Eva Mae Phelps

ITEM NO. SHOULD READ

13b

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>JACKSON</b>		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		a. STATE <b>KANSAS</b> b. COUNTY <b>MIAMI</b>		c. CITY OR TOWN <b>PAOLA</b>	
Length of stay in lb <b>8 WEEKS</b>		c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH HOSP.</b>		d. STREET ADDRESS <b>ROUTE 4</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MATILDA MAE SPENCER</b>				4. DATE OF DEATH Month Day Year <b>SEPT 7 1962</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-17-1893</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>		11. BIRTHPLACE (City and state or country) <b>BEATRICE, NEBR.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>JOHN H. GROCE</b>			13b. MOTHER'S MAIDEN NAME <b>EDNA MAE PHELPS</b>		14. NAME OF HUSBAND OR WIFE <b>JAMES E. SPENCER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>WILBURN COLLINS PAOLA, KANSAS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Metastatic CARCINOMA</b>							<b>3 yrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							
DUE TO (b) _____							
DUE TO (c) <b>Adenocarcinoma of Ovary</b>							<b>4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 a.m. p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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 <b>10/8/56</b> to <b>9/7/62</b> and last saw her alive on <b>9/7/62</b>				Death occurred at <b>11:55 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Leo F. Cooper MD</b> (Degree or title)			22b. ADDRESS <b>1220 E. 31st K.C. Mo.</b>		22c. DATE SIGNED <b>9-8-62</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>SEPT 10, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. WASHINGTON</b>		23d. LOCATION (City, town, or county) (State) <b>INDEPENDENCE, MISSOURI</b>		
24. FUNERAL DIRECTOR <b>C.H. BLACKMAN &amp; SON INC. K.C. MO.</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>9-10-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Song</b>		

BY AFFIDAVIT OF Informant: **I. F. Cooper**

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1220E31ST  
Dr. Cooper

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 Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address H. C., 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.

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