

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-005417
STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 244

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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25117

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF MEDICAL CERTIFICATION
R. W. Kieber, M.D.

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 58 years	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 405 N. 6th St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 405 N. 6th Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ORA Middle FRANKLIN Last SPENCER			4. DATE OF DEATH Month Feb. Day 23, Year 1963
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1895
9. AGE (last birthday) 67		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) retired teamster		10b. KIND OF BUSINESS OR INDUSTRY Transfer Company	11. BIRTHPLACE (City and state or country) Sibley, Iowa
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Ovanda Spencer	
13b. MOTHER'S MAIDEN NAME Elvira N. Fry		14. NAME OF HUSBAND OR WIFE Ethel M. Spencer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes		16. SOCIAL SECURITY NO. W. W. #1	
17. INFORMANT Mrs. Mildred Williams, 110 Mobile Home Dr.		Address St. Joseph, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unattended Death - Apparently DUE TO (b) Natural Causes. Investigated DUE TO (c) by the City Health Department.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I			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 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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ 10:00 _____ m on _____ date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Robert W. Kieber, M.D.</i>		22b. ADDRESS City Health Officer St. Joseph Mo	22c. DATE SIGNED 2-26-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/27/1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Missouri
24. FUNERAL DIRECTOR Heston-Bowman		ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Mar. 1, 1963
			26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Stoddell</i>

USE BLACK INK OR TYPEWRITER RIBBON

1963 MAR 5

MAR 5 1963

MAY 8 1963

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Permit issued 2-27/63

10-2

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 William Spillberg

Licensed Embalmer No. 4535

P. O. Address St Joseph, 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.