

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

3905 -63-018258  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **FILED APR 27 1963** Primary Registration District No. **1003** Registrar's No. \_\_\_\_\_

VS 300	DATE AMENDED
Rev. 4/59	
1	
2 <b>20</b>	
3	
4 <b>0</b>	
5 <b>1</b>	
6	
7 <b>0</b>	
8 <b>2</b>	
9	
10	
11	
12 <b>74-0</b>	
13	
<b>74</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY -----				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY -----							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Length of stay in 1b <b>life</b>			c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>3837 Wilmington</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER SPENCER</b>						4. DATE OF DEATH Month Day Year <b>April 5, 1963</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>8-4-1884</b>		9. AGE (last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>manufacturing</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>			
13a. FATHER'S NAME <b>Patrick Spencer</b>				13b. MOTHER'S MAIDEN NAME <b>Ellen Hennessey</b>				14. NAME OF HUSBAND OR WIFE <b>Mildred 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. [REDACTED]		17. INFORMANT Address <b>Mildred Spencer, 3837 Wilmington</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO (b) <i>Hypertensive Cordes From Disease</i> DUE TO (c) <i>443+</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										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 (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 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 <b>12:45 Pm</b> <b>1944</b> to <b>4-5-63</b> and last saw him alive on <b>4-5-63</b> . Death occurred at <b>12:45 Pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>Carl J. [Signature] MD.</i>						22b. ADDRESS <b>18 So. Kingshighway</b>		22c. DATE SIGNED <b>4-5-63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 8, 1963</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) <b>Amboy, Illinois</b>		(State)			
24. FUNERAL DIRECTOR <i>Arthur J. Donnelly</i>						ADDRESS <b>3840 Lindell Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>APR 6 1968</b>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>	

DR Fells  
18 S. Kings Highway

**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 Francis Williamson

Licensed Embalmer No. 3565

P. O. Address 3840 Kindele

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.