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United States of America – State of New Mexico – Vital Statistics

CERTIFICATE OF DEATH

Certified by Medical Investigator ☐
Certified by Physician ☒

(NOTE: If death due to accident, suicide, homicide, trauma, or unknown causes, refer case to Medical Investigator)

04505 306528

BERNALILLO (County of Death) ALBUQUERQUE (City, Town, Location)

DECEASED

1. DECEDENT – NAME First	Middle	Last	2. SEX	3. DATE OF DEATH (mo, day, yr)
CHARLES		SPENCER	MALE	JUNE 11, 1989

4. DATE OF BIRTH (mo, day, yr)	5a. AGE-last birthday	UNDER 1 YEAR MOS. 5b.	DAYS	UNDER 1 DAY HOURS 5c.	MINS.	6a. RACE – Specify White, Black, Native American, etc.	6b. IF NATIVE AMERICAN, Specify Tribal Affiliation (e.g. Zia, Jicarilla, Navajo, etc.)
JUNE 4, 1901	88					WHITE	

6c. DECEDENT HISPANIC? ☒ No ☐ Yes Specify: U.S. Southwest ☐ Mexican ☐ Cuban ☐ Puerto Rican ☐ Other ☐ Specify _____

7. EDUCATION OF DECEDENT – Indicate highest grade completed: 0 1 2 3 4 5 6 7 8 ☒10 11 12 13 14 15 16 17 + UNK

8a. HOSPITAL OR OTHER INSTITUTION – Name (If neither, give street and number): LOVELACE MEDICAL CENTER

8b. HOSPITAL: ☒ Inpatient ☐ ER/Outpatient ☐ DOA OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

9. STATE OR COUNTRY OF BIRTH	10. CITIZEN OF WHAT COUNTRY	11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED – Specify	12. SURVIVING SPOUSE (If wife, give birth name)	13. WAS DECEDENT EVER IN U.S. ARMED FORCES?
NEW MEXICO	USA	DIVORCED		☐ YES ☒ NO

14. SOCIAL SECURITY NUMBER	15a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	15b. KIND OF BUSINESS OR INDUSTRY
569-09-4705	SELF-EMPLOYED	FEED/LAUNDRY

16a. RESIDENCE – State	16b. County	16c. CITY, TOWN OR LOCATION	16d. INSIDE CITY LIMITS?
NEW MEXICO	TORRANCE	MOUNTAINAIR	☒ YES ☐ NO

16e. STREET AND NUMBER OR LOCATION: BOX 663 — 16f. ZIP CODE: 87036

PARENTS

17. FATHER – NAME First	Middle	Last	18. MOTHER – BIRTH NAME First	Middle	Last
BENJAMIN	B.	SPENCER	SARAH	E.	ADKINS

19a. INFORMANT – NAME (Type or print)	19b. MAILING ADDRESS Street/RFD No.	City/Town	State	Zip
CHARLESE SPENCER	11109 HIWE, N.E.	ALBUQUERQUE	NM	87112

DISPOSITION

20a. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Entombment ☐ Other (Specify) _____

20b. CEMETERY / CREMATORY – Name: MOUNTAINAIR CEMETERY

20c. LOCATION City/Town	State	21a. FUNERAL SERVICE LICENSEE or PERSON ACTING AS SUCH – Signature	21b. LICENSE NUMBER
MOUNTAINAIR	NM	LOLA A. HARRIS	#421

21c. FACILITY – NAME	21d. FACILITY – ADDRESS Street/RFD No.	City/Town	State
HARRIS-HANLON MORTUARY	BOX O	MOUNTAINAIR	NM

CERTIFICATION

CERTIFIER'S SIGNATURE – On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated.

☐ Office of Medical Investigator ☐ Tribal/Military Authority ☒ Certified Physician

22a. [signature] M.D.

DATE SIGNED (mo, day, yr)	HOUR OF DEATH
22c. 6/11/89	22d. 1915

PRONOUNCED DEAD (mo, day, yr)	PRONOUNCED DEAD (hour)
22e. 6/11/89	22f. 1915

22b. TYPE/PRINT NAME Lovelace Medical Center ADDRESS Albuquerque, NM

22g. MANNER OF DEATH: ☒ NATURAL ☐ ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ UNDETERMINED

REGISTRAR'S SIGNATURE 23a. [signature] — DATE FILED (Mo., Day, Yr.) 23b. 6-15-89

CAUSE OF DEATH

24a. WAS AN AUTOPSY PERFORMED?	24b. If yes, were findings considered in determining cause of death?	24c. LOCATION WHERE AUTOPSY WAS PERFORMED (CITY, STATE)
☐ YES ☒ NO	☐ YES ☒ NO	

25a. WAS RECENT SURGICAL PROCEDURE PERFORMED?	25b. IF YES, SPECIFY TYPE OF PROCEDURE	25c. DATE OF PROCEDURE	26a. WAS DECEDENT PREGNANT WITHIN LAST 6 WEEKS?	26b. If yes, estimated length of pregnancy
☐ YES ☒ NO			☐ YES ☒ NO	

27a. DESCRIBE HOW INJURY OCCURRED (COMPLETE FOR ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED)	27b. HOUR OF INJURY	27c. DATE OF INJURY-(MO, DAY, YR)

27d. INJURY AT WORK	27e. PLACE OF INJURY – Specify home, farm, street, etc.	27f. LOCATION Street/RFD No.	City/Town	State
☐ YES ☒ NO				

TYPE OR PRINT CLEARLY — PLEASE PRESS FIRMLY — MULTIPLE COPIES BEING MADE

28. PART I. Enter the diseases, injuries, or complications which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause per each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute Cardiovascular Collapse	Immediate
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury which initiated events resulting in death) LAST	b. Acute Infectious Myocardial Infection	7 days
	c.	
	d.	

DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STATE OF NEW MEXICO
COUNTY OF SANTA FE

CERTIFIED COPY OF VITAL RECORD
This is a true and exact reproduction of the document officially registered and placed on file in the Vital Statistics Section, Public Health Division, Health and Environment Dept.

Betty L. Vileman
State Registrar

DATE ISSUED 17 NOV 1989

071281

STATE OF OREGON: COUNTY OF KLAMATH: ss.

Filed for record at request of Edna M. Spencer the 24th day of Nov. A.D., 19 89 at 12:24 o'clock PM., and duly recorded in Vol. M89, of Deeds on Page 22725.

Evelyn Biehn County Clerk
By [signature]

FEE $8.00
Return: Edna M. Spencer
333 Hillandale, Belen, N.M. 87002