

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

4365440K

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis

(No. Jewish Hospital)

File No.

Registered No. 13

St. Ward)

2. FULL NAME

Samuel Spiegel

(a) Residence. No. 5370 Pershing Ave. St. 12 Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Nancy D. Spiegel

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 12, 1858

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<u>70</u>	<u>5</u>	<u>18</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. meat market

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Hillsboro Mo.

10. NAME OF FATHER

Abraham Spiegel

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Germany

14.

INFORMANT.....

Nancy D. Spiegel
(Address) 5370 Pershing Ave.

15.

FILED

JAN - 7, 1929

Ray C. Stanley

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1928 **to** Dec 30 1928 **that I last saw him alive on** Dec 30 1928 **and that death occurred, on the date stated above, at** 11:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage
arterio-sclerosis
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. 5 mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Jewish Hospital

DID AN OPERATION PRECEDE DEATH? No **DATE OF**

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Roulier exam
(Signed) A M Frank, M. D.

, 19 (Address) 714 Mc Wheeler Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Mt. Olive Jewish Cemetery

Jan. 1 1929

20. UNDERTAKER

ADDRESS

H. Rindaloff

5216 Delmar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

