

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH694
Do not use this space.

1. PLACE OF DEATH

(a) County.....¹ Registration District No.....⁷⁰¹
 (b) Township.....² Primary Registration District No.....^{BARROS HOSPITAL} Registered No.....⁶⁹⁴
 (c) City.....^{St. Louis Mo.} (d) Street No.....^{BARROS HOSPITAL} St.....
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

¹³¹¹ ^{OTTE} ^{SPIETH} ^{OTTO} ^{SPIETH}
 (a) Residence, No. ^{15 West of Square} St. ^{NR} ^{Jacksonville Ill}
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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 **CLARA SPIETH?**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **MAY 2nd 1899**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
59 8 20

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **PHOTOGRAPHER**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **GERMANY**

FATHER 13. NAME **CHRIS SPIETH**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **GERMANY**

MOTHER 15. MAIDEN NAME **ROSE HENGLMAN**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **GERMANY**

17. INFORMANT **MR. FRED SPIETH**
(ADDRESS) **OLNEY, ILLINOIS**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **JACKSONVILLE ILLINOIS** DATE **JAN. 25th 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS)
ALBERT H. HOPPE, SER. CO., INC.
4700 WASHINGTON, BLVD.

20. FILED 19 **39**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **1-22-39** 19

22. I HEREBY CERTIFY, That I attended deceased from **10-15-38**, to **1-22-39**, 1939
 I last saw him alive on **1-22-39**, 1939 Death is said to have occurred on the date stated above, at **11:00 a.m.**
 The principal cause of death and related causes of importance were as follows:

The principal cause of death and related causes of importance were as follows:
 Date of onset

Pyonephritis
Carcinoma of Urinary bladder
Perforation of bladder 3 days

Name of operation **Cystotomy** Date of **1-15-39**
 What test confirmed diagnosis? **Biopsy** Was there an autopsy? **yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury, 19
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) **H. Hoppe**, M. D.
 (Address) **BARROS HOSPITAL**

JAN 29 1939

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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

Registered Apprentice No....., working under my personal supervision.

Signed Guy W W Wilkinson

Licensed Embalmer No. 3575

P. O. Address

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 this body is not embalmed, above space should be left blank.