

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

34337
Do not use this space.
8875

1. PLACE OF DEATH ¹ ~~1930~~ NOV 13 1939 ²

(a) County..... Registration District No..... 791
 (b) Township..... Primary Registration District No..... 1003
 or
 City..... *St. Louis.* (d) Street No. *4242 1/2 Labadie ave* 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 *CATHARINE SPIES 120*

(a) Residence, No. *4242 1/2 Labadie ave* St. *10*
 (Usual place of abode, if no street address, write county or city) (If address death, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 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 *Charles Spies*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 13 - 1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 - 9 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Home Work*

9. Industry or business in which work was done, as saw mill, bank, etc. *At Home*

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) *Ill*

FATHER 13. NAME *John Schmidt*

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

MOTHER 15. MAIDEN NAME *Leont. Krieger*

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

17. INFORMANT (ADDRESS) *Charles Spies 4242 1/2 Labadie ave*

18. BURIAL, CREMATION, OR REMOVAL PLACE *St. Peters* DATE *Oct. 21 - 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Edw. P. Howard 4217 St. Louis ave*

20. FILE *OCT 18 1939* *J. B. Bredford Local Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *10-18-1939*

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at *6:10 a.m.*

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

*Chronic Myocarditis
Arteriosclerosis*

Other contributory causes of importance:
ABC

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? *no*

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) *J. B. Bredford* (Address) *St. Louis, Mo.*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

50M-3-19-38 I X16605

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.

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 Edw. J. Howard

Licensed Embalmer No. 1443

P. O. Address 4912 St. Louis Ave

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

34337
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
(b) Township..... Primary Registration District No. 1003
(c) City St. Louis (d) Street No..... 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 Catherine Spies

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED (SPIES)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
74 9 5

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 12/15/39 J. B. Bredek Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 - 18, 1939

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said to have occurred on the date stated above, at m.

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

Date of onset

Other contributory causes of importance:

Name of operation Date of.....

What test confirmed diagnosis? Was there an autopsy?.....

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) Joseph M. Duggan M. D.
(Address) Deputy

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

