

Registration District No. **1002**

Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution: 5340 Easton Ave
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County St. Louis
(c) City or town St. Louis
(d) Street No. 5340 Easton
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William E. Spore
3. (b) If veteran, name war NO
3. (c) Social Security No. NO

20. DATE OF DEATH: Month Nov day 8th
year 1939 hour 12 minute 30 AM

21. I hereby certify that I attended the deceased from Nov 3, 1939 to Nov 7, 1939 that I last saw him alive on Nov 7, 1939 and that death occurred on the date and hour stated above.

5. Color or race Male wh
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Alice Spore
6. (c) Age of husband or wife if alive 32 years
7. Birth date of deceased March 31 1851
(Month) (Day) (Year)

Immediate cause of death Sh. Myocarditis

8. AGE: Years 88 Months 7 Days 7 If less than one day _____ hr. _____ min.

Due to Age

9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

Due to Arteriosclerosis

10. Usual occupation Clk

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or business U.S. Post Office

MOTHER FATHER {
12. Name Mathis Spore
13. Birthplace St. Louis
14. Maiden name Mrs. M. M. M. M.
15. Birthplace St. Louis
(City, town, or county) (State or foreign country)

Major findings: _____
Of operations _____
Of autopsy none

16. (a) Informant's own signature Emma Croft
(b) Address 5340 Easton Ave

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)

17. (a) Rural (b) Date thereof Nov 11 - 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work _____ (Specify type of place)
(f) Means of injury _____

18. (a) Signature of funeral director Chas. H. Stewart
(b) Address 1225 Maple St
19. (a) NOV 10 1939
(Date received local registrar) (Registrar's signature)

23. Signature J. R. ...
Address 4500 Olive Date signed 11/11/39

Duration 3 yrs
PHYSICIAN 3 yrs
Underline the cause to which death should be charged statistically

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Pro-1-2
Foster Blvd

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..... *Albert G. Wapner*

Licensed Embalmer No. *20971*

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.