

FILED MAY 6 1943

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH: St. Louis

(a) County..... St. Louis

(b) City or town..... Koch

(c) Name of hospital or institution: Robt. Koch Hospital

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 2 mos

In this community..... life

(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri

(b) County.....

(c) City or town..... St. Louis

(If outside city or town limits, write "RURAL")

(d) Street No. 4244a W. St. Ferdinand

(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME: Spann, Robert Malcolm

3. (b) If veteran, name war.....

3. (c) Social Security No. 493-03-4145

4. Sex: male

5. Color or race: neg ro

6. (a) Single, widowed, married, divorced, single

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased: Oct. 12 1903

(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
39	5	22	.....hr. ....min.

9. Birthplace: St. Louis, Mo

(City, town, or county) (State or foreign country)

10. Usual occupation: chauffeur

11. Industry or business.....

MOTHER FATHER

12. Name: William Spann

13. Birthplace: Sedalia, Mo

(City, town, or county) (State or foreign country)

14. Maiden name: Mary Lewis

15. Birthplace: Oskaloosa, Kansas

(City, town, or county) (State or foreign country)

16. (a) Informant: pt. on entry to hospital

(b) Address.....

17. (a) Burial

(Burial, cremation, or removal) (b) Date thereof: 4-9-43

(Month) (Day) (Year)

(c) Place: burial or cremation: Lebanon Ill.

18. (a) Signature of funeral director: Peoples Und. Co.

(b) Address: 3100 FRANKLIN AVE. C.

19. (a) 4-5-43

(Date received local registrar) (b) C. G. MO... Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3

year 1943 hour 8 minute 00 P.M.

21. I hereby certify that I attended the deceased from 2/2/43 to 4/3/43

that I last saw him alive on 4/3/43

and that death occurred on the date and hour stated above.

Immediate cause of death: pulmonary tuberculosis

Duration: 6 mos?

Due to.....

Due to.....

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

Major findings: Of operations.....

Of autopsy: none done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)..... no

(b) Date of occurrence.....

(c) Where did injury occur?.....

(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work..... (Specify type of place) (e) Means of injury.....

23. Signature: [Signature] M.D. or other

Address: Koch Hospital, Koch Mo. Date signed: 4/4/43

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

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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.....

*Jodie Pettus*

Licensed Embalmer No.....

*4184*

P. O. Address.....

*St. Louis, Mo.*

**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, fact should be so stated above.**