

Registration District No. 317

Primary Registration District No. 3063

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day
In this community 12 years
years, months or days (Specify whether)

3. (a) PRINT FULL NAME

Jacob Spiess

3. (b) If veteran name war

3. (c) Social Security No. -

4. Sex MO

5. Color or race W

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

6. (b) Name of husband or wife Anna M Spiess

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased May 13 1869
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

75

4

27

hr.

min.

9. Birthplace

St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation

none

11. Industry or business

none

MOTHER FATHER

12. Name Jacob Spiess

13. Birthplace Berthony
(City, town, or county) (State or foreign country)

14. Maiden name Anna Ryan

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant

Anna Spiess

(b) Address

7918 Genesta Afton

17. (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

Oct. 13, 1944
(Month) (Day) (Year)

(c) Place: burial or cremation

New St. Marcus Cemetery

18. (a) Signature of funeral director

Wacker Hilderle

(b) Address

3634 Gravois Ave.

19. (a)

OCT 12 1944
(Date received local registrar)

E. J. McLawrence M.D.
(Registrar's signature)

23. Signature W. Majer M.D. (M. D. or other)
Address 601 Brentwood Clayton Date signed 11/1/44

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Afton
(If outside city or town limits, write "RURAL")
(d) Street No. 7918 Genesta
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country U.S.A.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10
year 1944 hour 9:20 minute A M.

21. I hereby certify that I attended the deceased from 10
9, 1944, to 10-10, 1944,
that I last saw him alive on 10-10, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decomp. & Pulmonary edema

Due to Hypertensive C.V. Disease

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93d
Of autopsy

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)
(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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

9/6
3

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 Robert Wheeler

Licensed Embalmer No. 2178

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, fact should be so stated above.