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FILED JAN 25 1945

318

Registration District No.

Primary Registration District No. 1003

State File No.

Registrar's No.

514

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

1. PLACE OF DEATH:

(a) County St. Louis Mo.

(b) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital Max C. Starkloff
(If not in hospital or institution, write street number or location) Memorial

(d) Length of stay: In hospital or institution 2 days (Specify whether
In this community 0 years, months or days)

3. (a) PRINT FULL NAME Fannie Spinney

3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Female 5. Color or race White 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 Sept 14th, 1865.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

79	4	2	hr. min.
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9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name William K. Spinney

13. Birthplace Not known
(City, town, or county) (State or foreign country)

14. Maiden name Lydia

15. Birthplace Not known
(City, town, or county) (State or foreign country)

16. (a) Informant Nora Laupp

(b) Address 4978 Quincy St.,

17. (a) Burial (b) Date thereof 1/19/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul's Chy'd

18. (a) Signature of funeral director J. J. Budeck
(b) Address 7027 Gravois Ave.

19. (a) JAN 18 1945 J. J. Budeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4978 Quincy St., (If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 11

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 16th
year 1945 hour 10:55 minute P. M.

21. I hereby certify that I attended the deceased from 1/14/45
....., 19..... to 1/16/45, 19.....
that I last saw her alive on 1/16/45, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Duration

Due to

Due to

Other conditions (include pregnancy within 3 months of death) 83

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations

Of autopsy same

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?

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

(Specify type of place) While at work?

(e) Means of injury 0

23. Signature James J. Hunt (M.D. or other)
Address 1515 Lafayette Date signed 1/16/45

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..... *B. P. Kidwell*

Licensed Embalmer No..... *3877*

P. O. Address..... *7027 Hawaii*

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.