

FILED NOV 29 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10026

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Sidney Rye Spaha

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 0

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

7. Birth date of deceased: 11 16 45
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 12 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Raymond Spahn

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

14. Maiden name Margaret Carlson

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

16. (a) Informant RAYMOND W. SPAHR

(b) Address 734 BROWNELL AVE KIRKWOOD

17. (a) BURIAL (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ST. PETERS CEM

18. (a) Signature of funeral director Myrl Helberg Funeral Home

(b) Address 23 W. Lockwood Blvd. Web B.

19. (a) NOV 20 1945 J. F. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town Kirkwood
(If outside city or town limits, write "RURAL")
(d) Street No. 734 Brownell
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 14
year 45 hour 2 minute 0-AM

21. I hereby certify that I attended the deceased from 11-16-45
_____ 19____ to 11-17-45 19____

that I last saw him alive on 11-17-45 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to pressure of labor & Prematurity
Due to premature labor

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

Major findings: _____
-Of operations _____

Of autopsy yes

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 _____

23. Signature W. H. Suley (M. D. or other) MD

Address 4160 Maryland Date signed 11-17-45

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

MOTHER, FATHER

96
4
NR3
1

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

ALABAMA BOARD OF EMBALMERS

10026

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.

Not Embalmed.

Signed.....

Licensed Embalmer No.....

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.