

FILED OCT 24 1947

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

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: Josephine Heitkamp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hours
(Specify whether
In this community 12 hrs.
years, months or days)

3. (a) PRINT FULL NAME Sandra Rochalle Spagnolia

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 Infant
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct 11 1947
(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 _____

MOTHER FATHER
12. Name Louis Thomas Spagnolia
13. Birthplace Philidelphia Pa.
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Elaine Lindell
15. Birthplace Clarence Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Carol Moody
(b) Address Milner Hotel, 18th at Washington
17. (a) Burial (b) Date thereof 10-13-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Alexander & Sons
(b) Address 617 S. Delmar Blvd
19. (a) OCT 13 1947 (b) J. F. Berbeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. (Reed Hotel) 1433 Pine St. (If rural, give location) 90
(e) Citizen of foreign country? 25 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11
year 1947 hour 2 minute P M.

21. I hereby certify that I attended the deceased from 11 Oct 1947 to 11 Oct 1947
that I last saw her alive on 11 Oct 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory Failure
Due to Pneumonia

Due to _____
Other conditions 139
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(c) 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) (c) Means of injury _____
23. Signature H. Dworkin (M. D. or other) MD
Address 1652 So Grand Date signed 11 Oct 47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 Thomas R. Jewick

Licensed Embalmer No. 3793

P. O. Address 6175 Helman

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.