S. No. 300
DM—10-47
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY # 41472
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38667

FILED DEC 14 1948

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10459

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(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 Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
In this community 15days
(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. 615 Walnut St.,
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Frank Spayd

3. (b) If veteran, name war

3. (c) Social Security No. OAA

4. Sex male

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 May (Month) 14th (Day) ? (Year)

8. AGE: Years abt 77 Months Days If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Ohio (State or foreign country)

10. Usual occupation OAA

11. Industry or business

FATHER
12. Name Henry Spayd
13. Birthplace unknown (City, town, or county) Penn. (State or foreign country)

MOTHER
14. Maiden name Swan Wittes
15. Birthplace unknown (City, town, or county) Penn. (State or foreign country)

16. (a) Informant M.Renard
(b) Address St.Louis City Hospital.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-2-48 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Cullen-Kelly
(b) Address 4386 Finkelly

19. (a) DEC 2 1948 (Date received local registrar) (b) J. B. Lassater (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 24th year 1948 hour 1 minute 20 P.M.

21. I hereby certify that I attended the deceased from 11-9-48, 19..., to 11-24-48, 19...; that I last saw him alive on 11-24-48, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Arteriosclerotic ht. disease	
Due to Congestive failure	
Due to	
Other conditions Broncho-pneumonia (Include pregnancy within 3 months of death)	

Major findings:
Of operations

Of autopsy

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

23. Signature W. Carter (M. D. or other)
Address 1515 Lafayette Avenue Date signed 11-24 1948

(Licensed Embalmer's Statement on Reverse Side)

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 Ralph W. Henson

Licensed Embalmer No. 3791

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.