

No. 300
-10-47
-17-39
PI 3906

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

39019
State File No. _____
2628
Registrar's No. _____

FILED DEC 4 1948

Registration District No. _____

Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Gardenville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Miller Nursing Home, 8140 Gravois Rd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) 4

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. 6900 West Park Ave
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Amelia Spinner

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 Divorced
6. (b) Name of husband or wife Otto Spinner 6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased 11/27/1882 8 2
(Month) (Day) (Year)

8. AGE: Years 65 Months 11 Days 11 If less than one day hr. _____ min. _____

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

10. Usual occupation At Home

11. Industry or business _____

12. Name August Kaiser

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

14. Maiden name Margaret Brook

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

16. (a) Informant Edwin Kaiser

(b) Address 6900 West Park

17. (a) Burial (b) Date thereof 11/10/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cemetery

18. (a) Signature of funeral director Robert J. Ambruster Inc.

(b) Address 6633 Clayton Road

19. (a) 11-9-48 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 8th
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death softening of brain due to arteriosclerosis Duration _____

Due to _____

Due to _____ 83 E

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

Major findings:
Of operations _____

Of autopsy as above

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) Natural Causes

(b) Date of occurrence November 8, 1948

(c) Where did injury occur? Afton, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Miller Nursing Home, Afton, Mo.

While at work? _____ (Specify type of place) (e) Means of injury Arterio-sclerosis

23. Signature Ernest J. Willmann Coroner
Address Clayton, Mo. Date signed 11/9/48

SEP 15 1950

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 *Ernest W. Spillars*

Licensed Embalmer No. *4080*

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.