

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36868

State File No. 9472
Registrar's No. 9472

FILED NOV 12 1952

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>JEFFERSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>BARNHART Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>BARNHART Mo</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ELIZABETH</u> b. (Middle) c. (Last) <u>SPRICH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 13, 1952</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>MAY 31, 1969</u>			9. AGE (In years last birthday) <u>83</u>		10. MONTHS <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Switzerland 5</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Gustave Sprich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Albert Sprich Barnhart</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u> <u>Prothrombotic states</u> DUE TO (b) <u>trochanteric, left</u> DUE TO (c) <u>femur L. m. 10/14/52</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>E9049</u>	

22. I hereby certify that I attended the deceased from 10/9/52 to 10/13/52, that I last saw the deceased alive on 10-12, 1952, and that death occurred at 3:30 P. m., from the causes and on the date stated above. 21

23a. SIGNATURE (Degree or title) <u>Maurice B. Rahn, M.D.</u>		23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>10/14/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct. 16, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>LEMAI Missouri</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HEILIGTAG FUNERAL HOME IMPERIAL Mo</u>		DATE REC'D BY LOCAL REG. <u>OCT 14 1952</u>	
REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>					

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

2056

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Elmer C. Heiligstein

Licensed Embalmer No. 2571

P. O. Address Imperial, 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.