

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23169

State File No.

FILED JUN 26 1953

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 5712

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kirkwood 4673	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If rural, give location) 1043 Wood Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) E. b. (Middle) FLORINE c. (Last) SPRINGS		4. DATE OF DEATH (Month) (Day) (Year) June 8, 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 13, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 54 IF UNDER 1 YEAR Month 4 Day 25 IF UNDER 1 HRS. Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) Marion, Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME G. C. Pierce		13b. MOTHER'S MAIDEN NAME Lucy Boaz	
14. NAME OF HUSBAND OR WIFE J. Glenn Springs		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME J. Glenn Springs, Kirkwood, Mo.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphatic Leukemia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH 8 months	
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) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 2040	
22. I hereby certify that I attended the deceased from Oct. 9, 1952, to June 8, 1953, that I last saw the deceased alive on June 8, 1953, and that death occurred at 9:00 am., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>Harriet E. Mueller</i> M.D.		23b. ADDRESS 634 N. Grand Blvd.	
23c. DATE SIGNED 6-9-53		24. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 6/10/53		24c. NAME OF CEMETERY OR CREMATORY Marion, Cemetery	
24d. LOCATION (City, town, or county) (State) Marion, Kentucky		25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS <i>Louis H. Gopp, M.D. Kirkwood Mo.</i>	
DATE REC'D BY LOCAL REG. JUN 9 1953		REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i>	

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

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 Felix Husband

Licensed Embalmer No. 3634

P. O. Address Kirkwood 2277

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.