

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

37614

State File No.

FILED OCT 30 1953

318

1003

10148

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>)		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2159	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The St. Louis Altenheim</u>				d. STREET ADDRESS (If rural, give location) <u>15 5408 S Broadway</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Emil</u> b. (Middle) _____ c. (Last) <u>Spiering</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 22 1953</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 19 1870</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>	IF UNDER 1 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cook</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Berlin Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John W. Hoerr 5408 S. Broadway</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Generalized carcinoma of spine, Pelvis and skull</u> ANTECEDENT CAUSES <u>Carcinoma of Prostate</u> 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. <u>Arterio Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8-17-50</u> <u>7. 28. 50</u> <u>?</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Prostate & Metastases 5-19-50</u>			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) <u>St. Louis Mo</u>			
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>177X</u>			
22. I hereby certify that I attended the deceased from <u>3-3</u> , 19 <u>49</u> , to <u>10-22</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>10-22</u> , 19 <u>53</u> , and that death occurred at <u>5:00P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Max Stahlhoff MD</u>			23b. ADDRESS <u>512 Dowdle</u>			23c. DATE SIGNED <u>10-23-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>10-24-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New St. Markus Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>OCT 26 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carly Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jos P. Fendler Jr. 7128 Michigan</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Clarence F. Chow

Licensed Embalmer No.

3093

P. O. Address

17128 Mack

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.