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FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35997

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8917**

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|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo. | | c. CITY OR TOWN Belleville | |
| c. LENGTH OF STAY (in this place) | | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL | | f. STREET ADDRESS (If rural, give location) 902 S. Illinois St. | |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Anita b. (Middle) Cora c. (Last) Spreitler | | | 4. DATE OF DEATH (Month) (Day) (Year) October 1, 1954 | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | |
| 8. DATE OF BIRTH Feb. 19, 1904 | | 9. AGE (In years last birthday) 50 | | 10. IF UNDER 1 YEAR: Months Days IF UNDER 1 HRS.: Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) Carlyle, Illinois | |
| 12. CITIZENRY OF WHAT COUNTRY? | | | | | |

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|--|--|---|--|---|--|
| 13a. FATHER'S NAME Henry Voland, Sr. | | 13b. MOTHER'S MAIDEN NAME Ann Sanders | | 14. NAME OF HUSBAND OR WIFE Anton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME Anton Spreitler | |
| | | | | ADDRESS 902 S. Illinois - Belleville | |

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|--|--|--|--|--|---|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | DUPLICATE TO (b) Hypertensive Cardiovascular Disease | | | 20 hrs. | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pyelonephritis | | | | |
| 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 checked="" type="checkbox"/> NO <input type="checkbox"/> | |

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|---|--|--|--|--|--|
| 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) 443X | |
| 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? | |

22. I hereby certify that I attended the deceased from **Sept. 17, 1954**, to **Oct. 1, 1954**, that I last saw the deceased alive on **Oct. 1, 1954**, and that death occurred at **1:30 Am.**, from the causes and on the date stated above.

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| 23a. SIGNATURE C. J. Vermillion, M.D. | | (Degree or title) | | 23b. ADDRESS BARNES HOSPITAL | |
| 23c. DATE SIGNED 10/1/54 | | 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE 10-4-54 | |
| 24c. NAME OF CEMETERY OR CREMATORY Walnut Hill | | 24d. LOCATION (City, town, or county) (State) Belleville | | | |

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|---|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. OCT 1 1954 | | REGISTRAR'S SIGNATURE J. Carl Smith | | 25. SANITARY DIRECTOR'S SIGNATURE John Gardner | |
| | | | | ADDRESS Belleville | |

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..

NOT EMBALMED

Student.....
Signature of Student Embalmer

Signed.....
Edw Gardner

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.