

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42838**
Registrar's No. **11259**

FILED DEC 17 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

| | | | |
|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. | c. LENGTH OF STAY (in this place) | c. CITY OR TOWN St. Louis | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: 6443a Idaho | | e. STREET ADDRESS (If rural, give location) 6443a Idaho | |

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|---|-------------------------------|---|--|---|---------------------------------------|-----------------------------|
| 3. NAME OF DECEASED (Type or Print) Agnes Spahn | | | 4. DATE OF DEATH (Month) (Day) (Year) Dec. 8, 1954 | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH May 17, 1895 | 9. AGE (In years last birthday) 59 | IF UNDER 1 YEAR Months Days | IF UNDER 10 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY none | 11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY? 0 | |

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|---|--|---|--|--|--|
| 13a. FATHER'S NAME Martin Nogalski | | 13b. MOTHER'S MAIDEN NAME Josephine Joblonski | | 14. NAME OF HUSBAND OR WIFE John Spahn | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unk | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Stella Miller 6443a Idaho | |

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|--|--|---|--|---|--|
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis | | INTERVAL BETWEEN ONSET AND DEATH Chronic | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis | | Chronic | |
| | | DUE TO (c) Renal Mellitus | | 5 yrs. | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing 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) | |

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|--|--|--|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 4221 | |
|--|--|--|--|--|--|

22. I hereby certify that I attended the deceased from **Nov 19, 1951**, to **Dec 8, 1954**, that I last saw the deceased alive on **Dec 3, 1954**, and that death occurred at **10a** m., from the causes and on the date stated above.

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|---|--|---|--|--|--|
| 23a. SIGNATURE (Degree or title) Dr. Charles M. D. ... | | 23b. ADDRESS 7701 ... | | 23c. DATE SIGNED 12/9/54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24b. DATE 12-11-54 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | |
| | | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. | | | |

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|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. DEC 10 1954 | | REGISTRAR'S SIGNATURE Carl Smith | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Southern Funeral Home 6322 S. Grand Blvd., St. Louis, Mo. | |
|---|--|---|--|---|--|

Dr R. C. Dripps

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.....
Signature of Student Embalmer

Signed *David Van Tassan*.....

Licensed Embalmer No. *424*.....

P. O. Address *322 So. 1st*.....

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.