

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14347

State File No.

BIRTH NO. 57561-54 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 904

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY OR TOWN <u>Bellefontaine Neighbors</u>		c. LENGTH OF STAY (in this place) <u>8 Months</u>		c. CITY OR TOWN <u>Bellefontaine Neighbors MO 20</u>		d. STREET ADDRESS (If rural, give location) <u>1069 1/2 Bellefontaine Road</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St. L. Training School</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) <u>ANN</u> c. (Last) <u>SPINN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 18 1955</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>July 29, 1954</u>		9. AGE (In years, last birthday) <u>2</u> MONTHS <u>8</u> DAYS <u>30</u> HOURS <u>11</u> MIN. <u>20</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert D. Spinn</u>			13b. MOTHER'S MAIDEN NAME <u>Marion Schneider Spinn</u>			14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert D. Spinn 3226 Indiana Ave.</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* (a) <u>Hypostatic Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> 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. <u>Hemoloid</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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>522X</u>			
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?			
22. I hereby certify that I attended the deceased from <u>10-11</u> , 19 <u>54</u> , to <u>4-18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 18</u> , 19 <u>55</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Edward P. Wryll</u> (Degree or title) <u>M.D.</u>			23b. ADDRESS <u>1069 1/2 Bellefontaine Road</u>			23c. DATE SIGNED <u>4/18/55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4/21/55</u>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <u>Altoona, Pennsylvania</u>	
DATE REC'D BY LOCAL REG. <u>4/19/55</u>		REGISTRAR'S SIGNATURE <u>Hebe K. Tomke</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Gebken Sons 2630 Gravois Ave.</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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Robert F. Gebken

Signed
Student Embalmer

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.