

FILED AUG 24 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29167

State File No.

BIRTH NO. REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6533**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Illinois b. COUNTY Madison			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 1 Month		c. CITY OR TOWN Collinsville		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist				f. STREET ADDRESS (If rural, give location) 107 Greenfield Dr			
3. NAME OF DECEASED (Type or Print) a. (First) Joseph			b. (Middle) Spence		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) July 11, 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 17, 1916		9. AGE (In years last birthday) 39	IF UNDER 1 YEAR Months 39	IF UNDER 1 HR. Hours 39
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Production Mgr. Iron Casting Co			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Green Tree Tenn		12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME Joseph Spence			13b. MOTHER'S MAIDEN NAME Verna Brawley		14. NAME OF HUSBAND OR WIFE Ruth Marshall Spence		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.#2		16. SOCIAL SECURITY NO. 710 10 9261		17. INFORMANT'S SIGNATURE OR NAME Ruth Spence ADDRESS Collinsville Ill			
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH						
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Ruptured Aneurysm, Cerebral						
ANTECEDENT CAUSES	Ruptured aneurysm, cerebral						
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	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 330x				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)			
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 6-8-56 , 19___, to 7-11-56 , 19___, that I last saw the deceased alive on 7-11-56 , 19___, and that death occurred at 1:30 A m. , from the causes and on the date stated above.							
23a. SIGNATURE Frank A. Palazzo				23b. ADDRESS 4161 Lindell Lindell Blvd.		23c. DATE SIGNED July 11, 1956	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE July 13 '56	24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		24d. LOCATION (City, town, or county) (State) Collinsville, Ill.		
DATE REC'D BY LOCAL REG. JUL 12 1956		REGISTRAR'S SIGNATURE J. Paul Smith M.D.		FUNERAL DIRECTOR'S SIGNATURE Chas M. Burke		ADDRESS East St. Louis, Ill	

3. (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.....
Signature of Student Embalmer

Signed.....
Chas M. Burke

Licensed Embalmer No....2421...

P. O. Address East St. Louis

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.