FILED JAN 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44972
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2868

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lemay — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 9353 S. BROADWAY — Length of stay in 16 5 mos.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri — b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location) 3324 LOUISIANA — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First ANNA Middle Last SPINNER

4. DATE OF DEATH Month DEC. Day 3 Year 1956

5. SEX Female

6. COLOR OR RACE WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH FEB. 27 1866

9. AGE (In years last birthday) 90 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW

10b. KIND OF BUSINESS OR INDUSTRY AT HOME

11. BIRTHPLACE (City and state or country) GERMANY

12. CITIZEN OF WHAT COUNTRY? U-S-A

13. FATHER'S NAME EDWARD MEIER

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. None

17. INFORMANT BERTHA SCHUG — Address 5442 NAGEL

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 3 yrs 6 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis — ?
DUE TO (c) Senelity — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION St Louis — COUNTY — STATE Mo

21. I attended the deceased from June 9 1954, to Dec 3 1956 and last saw her alive on Dec 1 1956
Death occurred at 10 " P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Max Starbloff MD

22b. ADDRESS 512 Dover Place

22c. DATE SIGNED 12/4/56

23a. BURIAL, CREMATION, REMOVAL (Specify) BEFORE

23b. DATE DEC. 6 1956

23c. NAME OF CEMETERY OR CREMATORY S. S. PETER & PAUL

23d. LOCATION (City, town, or county) ST. LOUIS (State) Mo

24. FUNERAL DIRECTOR Thomas Kutes — ADDRESS 2906 Gravois

25. DATE RECD. BY LOCAL REG. 12-4-56

26. REGISTRAR'S SIGNATURE Herbert R. Domke MD

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

512 Donner

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. Leo J. Budde

Licensed Embalmer No. 39

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.