

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11130

FILED APR 15 1957

318

1003

State File No. 3038  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			c. LENGTH OF STAY (in this place) <u>3 yrs.</u>		c. CITY OR TOWN <u>St. Louis</u>		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 <u>01 4967 Lindenwood Ave.</u>				e. STREET ADDRESS (If rural, give location) <u>14 4967 Lindenwood Ave.</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u>			b. (Middle) <u>F.</u>		c. (Last) <u>Spillenkothen</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3 27 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 21, 1880</u>		9. AGE (In years last birthday) <u>76</u>	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) <u>Machine Operator-Ret.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Rope</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>unknown</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Elizabeth Spillenkothen</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>488-09-8342</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Helen I. Spillenkothen</u> ADDRESS <u>4967 Lindenwood</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Chronic Cerebral cystitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unk</u> <u>5 yrs +</u>		
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) _____						
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? _____						
22. I hereby certify that I attended the deceased from <u>2/9, 1957</u> to <u>Nov 27, 1957</u> that I last saw the deceased alive on <u>Nov 27, 1957</u> and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.										
23a. SIGNATURE <u>Robert S. Warner M.D.</u> (Degree or title)				23b. ADDRESS <u>1115 Paul Brown Hall St. Louis Mo 28</u>			23c. DATE SIGNED <u>Nov 28 1957</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>3/30/57</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>				
DATE REC'D BY LOCAL REG. <u>MAR 28 57</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Drehmann-Harral</u> ADDRESS <u>1905 Union</u>					

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

Dr. Robert G. Warner  
Paul Brown Bldg.  
Ch. 1-4747

Hrs. 411 3:30 today 3/28  
1:30 3:30 3/29

**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 *Albert R. Thompson*

Licensed Embalmer No. *4237*

P. O. Address *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.