

Health,  
Welfare  
Public  
Service

300  
1-56

ALL diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. All other, coroner, etc. must use only standard nomenclature in item 18. All symptoms must be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 14 1957

318

1003

19323  
STATE FILE NUMBER  
5324

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <b>3400 S. Grand</b>		Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Agnes</b> Last <b>Spille</b>				4. DATE OF DEATH Month <b>June</b> Day <b>6th</b> Year <b>1957</b>				
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4, 1880</b>		9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (City and state or country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Adam Schaffer</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Theodore Spille (husband) 3400 S. Grand</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>420.0</b>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thirteen Days Post. Op. For Incarcerated Incisional Hernia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>	
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY		STATE				
21. I attended the deceased from <b>5-23-57</b> to <b>6-6-57</b> and last saw her alive on <b>6-6-57</b> Death occurred at <b>12:35 A. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>Edwin Haukekanis M.D.</b>				22b. ADDRESS <b>1515 Lafayette Ave.</b>		22c. DATE SIGNED <b>6-6-57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>re moval</b>		23b. DATE <b>6-10-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>			
24. FUNERAL DIRECTOR <b>Hoffmeister Mortuaries</b>			ADDRESS <b>7814 S. Broadway</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 7 '57</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		

(Licensed Embalmer's Statement on Reverse Side)

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 *Bill C. [Signature]* .....

Licensed Embalmer No. *47*

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.