

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034941

STATE FILE NUMBER

FILED OCT 14 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2557

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All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>ST LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>4000 MOLINE ACRES</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS COUNTY HOSP.</u>		Length of stay in lb <u>11 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>2303 GARDNER DR.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alvie J. White</u>			4. DATE OF DEATH Month Day Year <u>10-4-1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 8, 1882</u>	9. AGE (In years last birthday) <u>75</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>CARPENTER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	11. BIRTHPLACE (City and state or country) <u>TENNESSEE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>ROBERT WHITE</u>		13b. MOTHER'S MAIDEN NAME <u>LW BASFORD</u>		14. NAME OF HUSBAND OR WIFE <u>CLARA WHITE</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>597-07-7430</u>	17. INFORMANT Address <u>CLARA WHITE 2303 GARDNER</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage due to arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>9/22/58</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<u>331X</u> <u>10/4/58</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 <u>9-22-1958</u> to <u>10-4-1958</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>10-4-1958</u> Death occurred at <u>12:03 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Angelo A. Spasano MD</u>			22b. ADDRESS <u>601 S. BRENTWOOD, CLAYTON</u>		22c. DATE SIGNED <u>10-4-58</u>
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10/7/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		23d. LOCATION (City, town, or county) CO (State) <u>ST LOUIS MO</u> <u>601 S. Brentwood, Clayton</u>
24. FUNERAL DIRECTOR <u>DIEDRICH FUN. HOME 8319 HALSFERRY</u>		25. DATE RECD. BY LOCAL REG. <u>10-6-58</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Rompke MD</u>	

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 *Lawrence O. Heelan* .....

Licensed Embalmer No. *4979* .....

P. O. Address *St. Louis, Mo.* .....

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.