

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038243

STATE FILE NUMBER

78-81
FILED OCT 17 1958

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

9374

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Saint Mary's Infirmary</u>		Length of stay in lb <u>4 Hrs.</u>	d. STREET ADDRESS (If outside, give location) <u>3220 Johnson Lane</u>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Pius</u> Middle <u>-</u> Last <u>Spells</u>			4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1958</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months <u>4</u> Days <u>22</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Saint Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>

13a. FATHER'S NAME <u>Goritil Spells</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Weber</u>	14. NAME OF HUSBAND OR WIFE <u>-</u>
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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>None</u>	17. INFORMANT <u>Goritil Spells</u> Address <u>920 Johnson Lane, E. St. Louis, Ill.</u>
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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>Immaturity</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Immature delivery</u>	
	DUE TO (c) <u>Causes unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>776x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 _____ a.m. _____ p.m.	

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
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21. I attended the deceased from Birth to death and last saw ^{her} _{him} alive on 9-29-58
Death occurred at 3:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Leon O. Reed MD</u>	22b. ADDRESS <u>1410 E Broadway</u>	22c. DATE SIGNED <u>9/29/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>9/29/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Booker Washington</u>	23d. LOCATION (City, town, or county) (State) <u>Centreville Township, Illinois</u>
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24. FUNERAL DIRECTOR <u>Marion's Office</u> ADDRESS <u>2114 Mo. Ave. E. St. Louis, Ill.</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 30 '58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Secretary, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Not embalmed*
Arthur J. Lewis

Licensed Embalmer No.....

P. O. Address.....

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.