

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013859

STATE FILE NUMBER

FILED APR 20 1959

Registration District No. 162

Primary Registration District No. 5594

Registrar's No. 35

300  
1-57

4

1. PLACE OF DEATH a. COUNTY <b>JEFFERSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RURAL-MERAMEC</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b> 2039 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Josephs Hill</b> Length of stay in lb <b>1 yr 2 mo 90</b>		d. STREET ADDRESS (If outside, give location) <b>6617 ARSENAL</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Joseph</b> Last <b>SPAIN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</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>OCT. 6, 1888</b>
9a. AGE (In years last birthday) <b>70</b>		9b. IF UNDER 1 YEAR Months <b>7</b> Days	9c. IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBER</b>	11. BIRTHPLACE (City and state or country) <b>IRELAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>John J. Spain</b> 13b. MOTHER'S MAIDEN NAME <b>MARY CHARK</b> 14. NAME OF HUSBAND OR WIFE <b>MARGARET MALONEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <b>No</b>		16. SOCIAL SECURITY NO. <b>488-20-6190</b>	17. INFORMANT Address <b>Bro. Koch St. Josephs Hill Infirmary</b> <b>6617</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>CEREBRAL ARTERIO-SCLEROTIC CARDIO-VASCULAR-DISEASE</b> DUE TO (b) <b>PARALYSIS AGITANS</b> DUE TO (c) <b>PARALYSIS AGITANS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 Month, Day, Year a.m. p.m.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>334X</b>	
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 <b>1/26/58</b> to <b>4/5/59</b> and last saw <sup>her</sup> him alive on <b>4/3/59</b> Death occurred at <b>4/5/59</b> <b>1:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Dr. Marder M.D.</b>		22b. ADDRESS <b>St. Josephs Hill Infirmary</b>	22c. DATE SIGNED <b>4/5/59</b>
23a. (BURIAL, CREMATION, REMOVAL) <b>Removal</b>	23b. DATE <b>Apr. 8, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cajary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b> ADDRESS <b>3840 Linden Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>4-8-59</b>	26. REGISTRAR'S SIGNATURE <b>Robert C. Bauer</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Director, coroner, etc., must use only standard nomenclature in reporting - no symptoms with diagnosis. All diseases in Part I must be causally related.

356 APR 25

DATE RECEIVED  
APR 17 1955

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 *Francis Hillbomser* .....

Licensed Embalmer No. 3563  
P. O. Address 3840 .....

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.