

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019884  
STATE FILE NUMBER

FILED JUN 9 1959 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1502

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kirkwood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kirkwood</b> <b>4793.</b> 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>628 S. Sappington Rd.</b>		Length of stay in lb <b>1 Yr.</b>	d. STREET ADDRESS (If outside, give location) <b>628 S. Sappington Rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>GROVER</b> Middle <b>C.</b> Last <b>SPINNEY</b>	4. DATE OF DEATH Month <b>May</b> Day <b>30</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>10-12-1889</b>	9. AGE (In years last birthday) <b>69</b> 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) <b>Street Employee</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Municipality</b>	11. BIRTHPLACE (City and state or country) <b>Randolph Co., Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
---	--	---	--

13a. FATHER'S NAME <b>Sylvester Spinney</b>	13b. MOTHER'S MAIDEN NAME <b>Lucinda Woodside</b>	14. NAME OF HUSBAND OR WIFE <b>Mary J. Spinney</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>489-03-5444</b>	17. INFORMANT <b>Mary J. Spinney,</b> Address <b>above</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>Arteriosclerotic Heart Disease with Hypertension Terminal Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	
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 <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 _____
---	--	--	--

21. I attended the deceased from <b>7-23-42</b> to <b>5-30-59</b> and last saw her alive on <b>5-29-59</b> Death occurred at <b>11:30 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <i>Edmund C. Westrup</i> MD	22b. ADDRESS <b>204 E. Big Bend Kirkwood, Mo.</b>	22c. DATE SIGNED <b>6-1-59</b>
---	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6-2-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Lucas Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
--	----------------------------	---	--

24. FUNERAL DIRECTOR <b>JAY B. SMITH, Maplewood, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>6-2-59</b>	26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>
---	---	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 ..... *f. Allen Davis Jr.*

Licensed Embalmer No. *4053*

P. O. Address ..... *St. L.*

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.