

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034692**

**FILED OCT 13 1959**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2562

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b	c. CITY OR TOWN <b>University City</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>St. Marys Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8001 Gannon Ave</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>MARGARET SPRINGE METZ.</b>	First Middle Last	4. DATE OF DEATH <b>Sept. 24, 1959</b>	Month Day Year
--	-------------------	---	----------------

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>2/21/1895</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-------------------------	----------------------------------	---	--------------------------------------	-------------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	---	---	---

13a. FATHER'S NAME <b>Charles J. Springe.</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>John Irving Metz.</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>J. Irving Metz; 8001 Gannon Ave;</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>Massive Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Essential Hypertension</b>		<b>10 yrst</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) <b>Generalized arteriosclerosis</b>	PART III. if deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

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 Month, Day, Year 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 **1957** to **9-24-59** and last saw him alive on **9-24-59**  
Death occurred at **4:45 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>A. J. Steiner MD</b>	22b. ADDRESS <b>3720 Washington</b>	22c. DATE SIGNED (State) <b>9/25/59</b>
---	--	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Enombment</b>	23b. DATE <b>9/26/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Mausoleum.</b>	23d. LOCATION (City, town or county) (State) <b>St. Louis County, Missouri.</b>
---	-------------------------------	---	--

24. FUNERAL DIRECTOR ADDRESS <b>C. R. LUPTON &amp; SONS; 7233 Delmar Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>9-25-59</b>	REGISTRAR'S SIGNATURE <i>[Signature]</i>
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Arnold W. Schoen*

Licensed Embalmer No.

*3864*

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.