

FEDERAL BUREAU OF INVESTIGATION  
**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-042547**

**FILED VS NOV 3 0 1959**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **210583**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>55yrs</b>		c. CITY OR TOWN <b>St. Louis</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>4517 Enright Avenue</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4517 Enright Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>A</b> Last <b>SPOTTS</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>13</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</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>7-8-1874</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>5</b>	IF UNDER 24 HR Hours <b>5</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Weston Missouri</b>		11. BIRTHPLACE (City and state or country) <b>U S A</b>		
13a. FATHER'S NAME <b>Henry Spotts</b>			13b. MOTHER'S MAIDEN NAME <b>Joanna ?</b>			14. NAME OF HUSBAND OR WIFE <b>Rhoda Spotts</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>495-32-8078</b>		17. INFORMANT Address <b>Rhoda Spotts 4517 Enright Avenue</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 apoplexy</b> <b>Cerebral Apoplexy</b> <b>hypertension</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>hypertension</b> DUE TO (c) <b>334x</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b> <b>1 1/2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 _____ a.m. _____ p.m.		Month, Day, Year _____					
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.) <b>8-1-59</b>		20f. CITY, TOWN, OR LOCATION <b>11-13-59</b>		COUNTY STATE <b>11-13-59</b>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>4 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Walter A. Young</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>4635 Easton</b>		22c. DATE SIGNED <b>11-13-59</b>	
23b. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11/18/59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co Mo</b>	
24. FUNERAL DIRECTOR ADDRESS <b>JAS H. RANDLE &amp; SON 3133 Bell Ave</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 17 1959</b>		26. REGISTRAR'S SIGNATURE <b>Road Smith, M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

*Escher H. Harris*

Licensed Embalmer No. 4450

P. O. Address 4181 3<sup>rd</sup> St

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.