

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

'59 0 4 6 3 3 3

FILED VS DEC 21 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3119

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Florissant</u>		Length of stay in 1b <u>10 Yrs</u>	c. CITY OR TOWN <u>Florissant</u> 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>2305 Johnstown Dr.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>2305 Johnstown Dr.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Spiller</u> Last <u>Spiller</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/70</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Unk. Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Lawson Williams</u>			13b. MOTHER'S MAIDEN NAME <u>Caroline Moore</u>		14. NAME OF HUSBAND OR WIFE <u>Albert (Deceased)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Ethel Kohler, 2305 Johnstown Dr.</u>	

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>Unknown Natural Cause</u>		INTERVAL BETWEEN ONSET AND DEATH
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)		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	
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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.)	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____

21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
 Death occurred at 9:10P m on the date stated above, and to the best of my knowledge, from the causes stated.

21a. SIGNATURE (Name and title) <u>John C. Murphy, MD (Asst. Health Commissioner)</u>	22b. ADDRESS <u>801 S. Brentwood Clayton, Mo.</u>	22c. DATE SIGNED
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/24/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis City, Mo.</u>
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24. FUNERAL DIRECTOR <u>McLaughlin, 2301 Lafayette St. Louis, L, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-21-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James R. Chapin*

Licensed Embalmer No. 43

P. O. Address St. Louis

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.