

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021850

FILED VS. MAY 31 1960 317

Registration District No. 547 Primary Registration District No. 1644 Registrar's No.

STATE FILE NUMBER

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> 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 <b>2 Weeks</b>	c. CITY OR TOWN <b>Overland</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 Hospt.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8208 John Pl.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bernard</b> Middle <b>J</b> Last <b>Einspanier</b>			4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Male</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>7-11-1900</b>	9. AGE (last birthday) <b>59</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lay-out Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nooter, Co</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>Herman Einspanier</b>		13b. MOTHER'S MAIDEN NAME <b>Anna U<sup>ny</sup>k</b>		14. NAME OF HUSBAND OR WIFE <b>Cleda Einspanier</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>UNK</b>	17. INFORMANT Address <b>Cleda Einspanier 8208 John Pl.</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>Brain Lesions - metast.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>Lung Ca (vs T.B?)</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>Chronic chest condition</b>				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 checked="" type="checkbox"/> NO <input 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Month, Day, Year					
20d. INJURY OCCURRED 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>5-10-60</b> to <b>5-22-60</b> and last saw her alive on <b>5-22-60</b> . Death occurred at <b>11:00P</b> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Frank H. Palozzo M.D.</b> (Degree or title)			22b. ADDRESS <b>4161 Lindell</b>		22c. DATE SIGNED <b>5-23-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)		
<b>Burial</b>	<b>5-26-60</b>	<b>Lake Charles Cemetery</b>	<b>St. Louis, Co. Mo.</b>		
24. FUNERAL DIRECTOR <b>J.W. Clark F.H. 1125 Hodiamont Ave</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>5-23-60</b>	26. REGISTRAR'S SIGNATURE <b>John M. [Signature]</b>	

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 Alfred J. Breda  
Licensed Embalmer No. 26

P. O. Address 11257th

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.

*02-22-72*