RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-031505

STATE FILE NUMBER

ILED VS SEP 14 1960

IDED

Registration District No. 257 Primary Registration District No. 5880 Registrar's No. 45

1. PLACE OF DEATH
a. COUNTY Osage
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Crawford Twp
Length of stay in 1b 4 mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lem Manor Rest Home
Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo
b. COUNTY St Louis
c. CITY OR TOWN St Johns
Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 3519 Lindscott (If outside, give location)
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First August Middle J Last Sporleder
4. DATE OF DEATH Month Sept Day 11 Year 1960
5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 11/25/79
9. AGE (last birthday) 80
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) Agent
10b. KIND OF BUSINESS OR INDUSTRY Insurance
11. BIRTHPLACE (City and state or country) St Louis Mo
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME August Sporleder
13b. MOTHER'S MAIDEN NAME Mary (unknown)
14. NAME OF HUSBAND OR WIFE May Sporleder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Melba Sporleder Address 3519 Lindscott

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis, generalized
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Prostatitis & Cystitis, Chronic
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 5-7-60, to 9-11-60 and last saw ~~her~~ him alive on 9-8-60
Death occurred at 10 50 A m on the date stated above, and to the best of my knowledge, from the causes stated.
22a. SIGNATURE Thomas W. Baldwin (Degree or title) D.O.
22b. ADDRESS Linn
22c. DATE SIGNED 9-11-60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 9/14/60
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St Louis Mo (State)
24. FUNERAL DIRECTOR Ortmann F Home ADDRESS 9222 Lackland Overland Mo
25. DATE RECD. BY LOCAL REG. 9-13-60
26. REGISTRAR'S SIGNATURE Mrs. Leyde Morton

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

SEP 15 1960

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_____ Signed Vernon M. Morton

Signature of Student Embalmer

Licensed Embalmer No. 4125

P. O. Address Lenin M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.