

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032907

FILED VS. SEP 8 1960 318

1003

STATE FILE NUMBER

8483

NDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		a. STATE Illinois b. COUNTY Washington	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital		c. CITY OR TOWN New Minden	
Length of stay in lb		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Wayne	Middle Leroy	Last Sprehe	4. DATE OF DEATH	Month August	Day 26	Year 1960
-------------------------------------	-----------------------	------------------------	-----------------------	------------------	------------------------	------------------	---------------------

5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/29/1941	9. AGE (last birthday) 19	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) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and state or country) New Minden, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.
---	--	---	--

13a. FATHER'S NAME Leroy Sprehe	13b. MOTHER'S MAIDEN NAME Verena Dries	14. NAME OF HUSBAND OR WIFE None
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 321-32-0689	17. INFORMANT Leroy Sprehe, New Minden, Ill.	Address
---	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Subarachnoidal Hemorrhage*

DUE TO (b) *Retroperitoneal Hemorrhage*

DUE TO (c) _____

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE ORIGINAL DISEASE CONDITION GIVEN IN PART I (a) *Myocardial infarction between motor cycle*

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. PLACE OF INJURY (Specify street, house, etc.) <i>operated by one, Frank Gachy at the intersection of N. of Morris and Blair St.</i>
--	--	---

20c. TIME OF INJURY 3:20 p.m.	Month, Day, Year 8 26 60	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 25 Street	20f. CITY, TOWN, OR LOCATION St. Louis Mo.	COUNTY	STATE
---	------------------------------------	--	--	--------	-------

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____

Death occurred at _____ **3:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Patrick J. Taylor Carraway</i>	(Degree or title)	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 8.29.60
---	-------------------	-----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-29-60	23c. NAME OF CEMETERY OR CREMATORY St. John's Lutheran Cemetery	23d. LOCATION (City, town, or county) New Minden, Ill.	(State)
---	-----------------------------	---	--	---------

24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	ADDRESS	25. DATE RECD. BY LOCAL REG. AUG 29 1960	26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</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 J. W. D. Densley

Licensed Embalmer No. 369

P. O. Address Hoosier

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