

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

7262-62-029194
STATE FILE NUMBER

318 Primary Registration District No. 1003 Registrar's No.

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7262-62-029194

FILED AUG 6 1962

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | | | | | | | | |
|--|--|--|--|--|---|---------------------------------------|------------------------------|---|---|--|
| 1. PLACE OF DEATH a. COUNTY | | b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN | | Length of stay in 1b | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE | | b. COUNTY | c. CITY OR TOWN | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | 917 Geyer Ave | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS | | 917 Geyer Ave | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | | First | Middle | Last | 4. DATE OF DEATH | | Month | Day | Year |
| | | | Lloyd | Ivan | Spaulding | | | July | 20 | 1962 |
| 5. SEX | 6. COLOR OR RACE | 7. Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> | Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH | | 9. AGE (last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HR |
| Male | White | # | | 2/21/09 | | 53 | | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) | | 12. CITIZEN OF WHAT COUNTRY | | | | |
| Teamster | | | | Flat River Mo. | | U S | | | | |
| 13a. FATHER'S NAME | | | 13b. MOTHER'S MAIDEN NAME | | | 14. NAME OF HUSBAND OR WIFE | | | | |
| Thomas Spaulding | | | Alice Mary ? | | | None | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | | | | Mary Loncaric | | 1800 Preston Place | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Coronary sclerosis with occlusion |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | | | 4201 |
| 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 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 | 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 live on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) | | | | | 22b. ADDRESS | | | 22c. DATE SIGNED | | |
| Paul J. Simon Deputy Coroner | | | | | 1300 Clark | | | 7/24/62 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) | | | | |
| Removal | | 7/24/62 | | New St Marcus Cemetery | | St Louis county Mo | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE | |
| Moydell Funeral Home | | | | | 1926 Allen | | JUL 24 1962 | | Kean Smith, M.D. | |

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 Harley J. Joella
Licensed Embalmer No. 4950

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.