

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032922

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

8319

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED AUG 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b Unknown	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4511 Laclede			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Regina Gertrude Middle SPALDING Last				4. DATE OF DEATH Month August Day 25 Year 1962		5. SEX Female		6. COLOR OR RACE Caucasian	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4-13-89	9. AGE (last birthday) 73	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) Dress Maker				10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (City and state or country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U.S.					
13a. FATHER'S NAME Edward Spalding			13b. MOTHER'S MAIDEN NAME Agnes Klunk			14. NAME OF HUSBAND OR WIFE Single							
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.		17. INFORMANT Addie Spalding, 4511 Laclede							
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) INTRACEREBRAL HEMMORRHAGE										8 DAYS			
DUE TO (b) GENERALIZED ARTERIOSCLEROSIS										10 YRS			
DUE TO (c) SENILITY										331 X			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROTIC HEART DISEASE & FIBRILLATION										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			
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 JAN 3, 1953 to AUG 25, 1962 and last saw her alive on AUG 25, 1962 . Death occurred at 8:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>James H. Cummings</i>				(Degree or title) M.D.		22b. ADDRESS 424 N. Euclid Ave		22c. DATE SIGNED 8-26-62					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-28-1962		23c. NAME OF CEMETERY OR CREMATORY St. Aloysius Cemetery		23d. LOCATION (City, town, or county) Littlestown, Pennsylvania		(State)					
24. FUNERAL DIRECTOR <i>Arthur G. Connolly</i>				ADDRESS 3840 Lindell Blvd.		25. DATE RECD. BY LOCAL REG. AUG 27 1962		26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>					

*Dr. [unclear]
[unclear]*

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 *[Signature]*

Licensed Embalmer No. 4699

P. O. Address 384 [unclear]

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.