

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-038489

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2914

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

4000
24000

3

4 1

5 0

6

7 2

8 R

9 4500

10

11

12 90-0

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP if applicable) OR TOWN Spanish Lake, Mo.		Length of stay in 1b 1 year	c. CITY OR TOWN Spanish Lake, Mo. Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1805 Claudine Drive		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1805 Claudine Drive Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ANNA Middle K. Last STUDT			4. DATE OF DEATH Month September Day 17 , Year 1963
5. SEX Female	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 3-14-1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (last birthday) 88 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) Germany		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Jacob Studt		13b. MOTHER'S MAIDEN NAME Charlotte Heil	
14. NAME OF HUSBAND OR WIFE Mr. Arthur Lobeck, Glenview, Illinois		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Arthur Lobeck, 724 Hunter Road, Glenview, Illinois	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis don't know DUE TO (b) _____ 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 terminal disease condition given in PART I (a) none		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 St. Louis COUNTY _____ STATE _____
21. I attended the deceased from 6-23-62 to 9-17-63 and last saw her DEAD relative on 9-17-63 Death occurred at 6:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Walter H. Spenneman		22b. ADDRESS 1515 St. Louis	22c. DATE SIGNED 9-19-63
23a. BURYAL OR REMOVAL (Specify) Burial	23b. DATE Sept. 19, 1963	23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
24. FUNERAL DIRECTOR CALVIN F. FEUTZ, 4828 Natural Bridge Bl.		25. DATE RECD. BY LOCAL REG. 9-19-63	26. REGISTRAR'S SIGNATURE John M. Murphy, M.D.

(Licensed Embalmer's Statement on Reverse Side)

Dr. W. H. Spoeneman
1515 St. Louis Avenue
CE 1-0638

FILE IN COUNTY

HOURS: No Wed. Hours
Thurs. ~~XXXXXX~~
be at office at 10:30 AM

10 4 4

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 John A. Melvin
Licensed Embalmer No. 4186

P. O. Address St Louis Mo

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.