

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D APR 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8443
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City..... **St. Louis** (d) Street No. **3438 Vista ave** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred **60** yrs. **10** mos. **6** ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **2208**

2. PRINT FULL NAME **JOHN - J. SPELMAN**

(a) Residence, No. **3438 Vista ave** St. **18** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (write name) **Catherine - Spelman**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **APRIL 29, 1878**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 10 6
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Retired - P.O. Dept**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation **36**

12. BIRTHPLACE (CITY OR TOWN) **ST. LOUIS**
(STATE OR COUNTRY) **MISSOURI**

13. NAME **DOMINIC SPELMAN**

14. BIRTHPLACE (CITY OR TOWN) **Ireland**
(STATE OR COUNTRY)

15. MAIDEN NAME **MARGARET M. GODFREY**

16. BIRTHPLACE (CITY OR TOWN) **Ireland**
(STATE OR COUNTRY)

17. INFORMANT (ADDRESS) **John J. Spelman**
13429 Vista - St Louis Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **3/9, 1939**

19. FUNERAL DIRECTOR (NAME) **Edw. F. Howard & Son**
(ADDRESS) **4212 St. Louis ave**

20. FILED **7 1939**
J. B. Bridger
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **March 6, 1939**
22. I HEREBY CERTIFY That I attended deceased from **Dec 7** to **28 March 6, 1939**
I last saw **L** alive on **March 4, 1939** Death is said to have occurred on the date stated above, at **9:50 AM**.
The principal cause of death and related causes of importance were as follows:

Pericardial myofascia
Date of onset

Other contributory causes of importance:

Name of operation **None** Date of **No**
What test confirmed diagnosis **Depend** Was there an autopsy **No**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide Date of injury **19**
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury **No**

24. Was disease or injury in any way related to occupation of deceased?
If so, specify **No**
(Signed) **M. J. [Signature]** M. D.
(Address) **1446 S. Grand**

522

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Edw. J. Howard

Licensed Embalmer No. 1443

P. O. Address 4212 St. Louis ave

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8443
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791
(b) Township..... Primary Registration District No. 1003
(c) City St. Louis (d) Street No. Registered No. 2208
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John J. Spelman

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 10 6

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 6-13 1939 J. F. Bredeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 6, 1939

22. I HEREBY CERTIFY, That I attended deceased from to

I last saw him alive on, 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemiplegia followed cerebral hemorrhage
Date of onset

Other contributory causes of importance:

Name of operation none Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) W. B. DePeck, M. D.
(Address) 1446 S Grand

SUPPLEMENTARY

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

