

SEP 25 1940

Registration District No. **791**Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5302a Wabada Ave. **2**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)
 In this community _____
 years, months or days

8. (a) PRINT FULL NAME **Harry Spehr** **160**
 8. (b) If veteran, name war _____
 8. (c) Social Security No. **488-09-8614**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Marie Spehr**
 6. (c) Age of husband or wife if alive **40** years
 7. Birth date of deceased **Aug. 28 1895**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 11 24 hr. min.

9. Birthplace **St. Louis Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Salesman**
 11. Industry or business **Prudential Ins. Co.**

MOTHER FATHER
 12. Name **Louis Spehr**
 13. Birthplace **N. Y.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown Reilly**
 15. Birthplace **St. Louis Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Marie Spehr**
 (b) Address **5302a Wabada Ave.**

17. (a) **Burial** (b) Date thereof **8-26-40**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem.**

18. (a) Signature of funeral director **Drehmann-Harral**
 (b) Address **1905 Union Blvd.**

19. (a) **AUG 24 1940** (b) **J. T. [Signature]**
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
 (c) City or town **St. Louis** **L**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5302a Wabada Ave.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **22**
 year **1940** hour **2** minute **25** P. M.

21. I hereby certify that I attended the deceased from **June 3, 1938**
 _____, 19____, to **Aug 22, 1940**, 19____;
 that I last saw him alive on **Aug 22, 1940**, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Colo.**
Caecal carcinoma of GI tract - originating in transverse colon.
 Duration **over 2 yrs.**

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: **Examina of transverse colon.**
 Of operations _____
 Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (a) Means of injury _____

23. Signature **Clarence G. [Signature]** (M. D. or other)
 Address **1927 3 Union** Date signed **8/23/40**

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.

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 *Warren A. Carver*

Licensed Embalmer No. *3534*

P. O. Address.....

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.