

NOV 16 1940 791

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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:
Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo (Specify whether
In this community 59 years years, months or days)

3. (a) PRINT FULL NAME Malinda Spauling

3. (b) If veteran, name war _____ 3. (c) Social Security No. Unk

4. Sex F 5. Color or race Negro 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Unk 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 10, 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 1 9 hr. min.

9. Birthplace Ark
(City, town, or county) (State or foreign country)

10. Usual occupation ?

11. Industry or business ?

12. Name of informant Seaben McCullen

13. Birthplace ?
(City, town, or county) (State or foreign country)

14. Maiden name Pollie ?

15. Birthplace ?
(City, town, or county) (State or foreign country)

16. (a) Informant Lorence A Spotts
(b) Address 2601 N Whittier

17. (a) (Burial, cremation, or removal) ? (b) Date thereof 9-28-40
(Month) (Day) (Year)

(c) Place: burial or cremation ?

18. (a) Signature of funeral director W. T. Rishard
(b) Address 3500 Rugby

19. (a) OCT 1 1940 (b) J. B. [Signature]
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St Louis 26
(If outside city or town limits, write "RURAL")
(d) Street No. 814 LaBaume
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19
year 1940 hour 6:20 minute _____ A. M.

21. I hereby certify that I attended the deceased from August 19, 1940 to Sept 19, 1940;
that I last saw h. er alive on Sept 19, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Hyper. Heart Disease Duration 5 yrs

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

(Specify type of place) (e) Means of injury _____

23. Signature J. W. Johnson M.D. (M. D. or other) _____
Address 2601 N Whittier Date signed 9/23/40

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.....

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.