

BUREAU OF VITAL RECORDS  
**FILED AUG 5 1946**

Registration District **317**

Primary Registration District No. **3063**

Registrar's No. **1589**

1. PLACE OF DEATH:

(a) County **St. Louis County**  
**Champion St. Louis County Hospital**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Louis County Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: in hospital or institution. **1 1/2** 45 min  
(Specify whether  
In this community **life**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **410 N York**  
(If rural, give location)  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME

**William Spens**

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **M**

5. Color or race **Col**

6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive, years

7. Birth date of deceased **Feb 26 1929**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**17 5 1** hr. min.

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

10. Usual occupation **Student**

11. Industry or business

12. Name **Wm Spens Sr.**

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

14. Maiden name **Rubena Mang**

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

16. (a) Informant **Father**

(b) Address **410 N York**

17. (a) **Burial** (b) Date thereof **7-31-1946**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter's Conv. St. Louis**

18. (a) Signature of funeral director **John H. Dempsey**

(b) Address **408 S. Illinois St. St. Louis Mo**

19. (a) **7-31-46** (b) **Edm. Sarant**  
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month **7** day **27** year **1946** hour **4** minute **45** A. M.

21. I hereby certify that I attended the deceased from **7-27 46** to **7-27 46** that I last saw him alive on **7-27 46** and that death occurred on the date and hour stated above.

Immediate cause of death **Concussion of brain and skull fracture sustained in auto accident**  
Due to **accident**  
Due to **1700**  
Other conditions (Include pregnancy within 3 months of death)

Major findings: 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) **Accident - 92**  
(b) Date of occurrence **7/27/46**  
(c) Where did injury occur? **Public Highway, St. Charles County**  
(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)  
While at work? **No** (Specify means of injury)  
23. Signature **Edm. Sarant** (M. D. or other)  
Address **601 Parkview** Date signed **7-29-46**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
23643  
6  
237

**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 Wm. L. Howell

(Licensed Embalmer No. 2452)

P. O. Address 2834 Gamble

**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, fact should be so stated above.