No. 2
-1/47
17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED MAY 9 1947
318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15670

Registration District No. #42975 Primary Registration District No. 1003 Registrar's No. 4295

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

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis City Hospital, Max Starkloff (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Memorial (Specify whether)

In this community (years, months or days) 0

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 003 17

(c) City or town St. Louis 10 9 (If outside city or town limits, write "RURAL")

(d) Street No. 3627 Sullivan 0 (If rural, give location)

(e) Citizen of foreign country? No. (~~Yes or~~ No)

If yes, name country

3. (a) PRINT FULL NAME MARJORIE SPITZMILLER

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex FEMALE 1

5. Color or race W

6. (a) Single, widowed, married, divorced WIDOWED 2

6. (b) Name of husband or wife Benedict

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

7. Birth date of deceased August (Month) 10 (Day) 1879 (Year)

8. AGE: Years 67 Months 8 Days 14 ~~15~~ If less than one day hr. min.

9. Birthplace Reynolds County Mo. 1 (City, town, or county) (State or foreign country)

10. Usual occupation House WIFE

11. Industry or business —

FATHER
12. Name ELT Barber
13. Birthplace Pennsylvania 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant Estel Hairgrove
(b) Address 3627 Sullivan

17. (a) (Burial, cremation, or removal) (b) Date thereof 4/28/47 (Month) (Day) (Year)
(c) Place: burial or cremation St Peter

18. (a) Signature of funeral director St Louis Funeral Home
(b) Address 2205 St Louis ave

19. (a) APR 27 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24th year 1947 hour 6:55 minute P M.

21. I hereby certify that I attended the deceased from 4-8-47, 19..., to 4-24-47, 19...; that I last saw her alive on 4-24-47, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Subarachnoid Hemorrhage	30 days
Due to Hypertension	Years
Due to	
Other conditions Uremia (Include pregnancy within 3 months of death)	30 days

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature John A. Kinner M.D. or other M.D.
Address 1515 Lafayette Date signed 4-25-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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, fact should be so stated above.