

No. 30  
M-10-47  
5-17-39  
I 3908

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED DEC 31 1948

Registration District No. 3064

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3064

State File No. 42034

Registrar's No. 2780

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

1. PLACE OF DEATH:

(a) County Ferguson  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
O'Sullivan Nursing Home 4  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether years, months or days) 1 day

3. (a) PRINT FULL NAME FRED W. SPIES  
3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: June 15 1885  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
63 5 15 hr. min.

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

10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Henry Spies  
13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)  
14. Maiden name Katherine Schripl  
15. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

16. (a) Informant Albert Spies  
(b) Address 3701 Sulphur

17. (a) Burial (b) Date thereof Dec 2 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter & Paul

18. (a) Signature of funeral director C. Hoffmeister Colonial Mortuary  
(b) Address 6464 Chippewa St.

19. (a) 12/1/48 (b) Thuraid V. Lueinger MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3630a Winnebago St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30:  
year 1948 hour 4 minute 05 P.M.

21. I hereby certify that I attended the deceased from July 18th, 1948, to Nov. 30th, 1948;  
that I last saw him alive on Nov. 27th, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration  
Acute Myocarditis 3 days

Due to Arteriosclerosis and

Due to Chronic Nephritis 3 Mo.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 131B

Major findings:  
Of operations none  
Of autopsy no  
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) (e) Means of injury \_\_\_\_\_

23. Signature W. A. Walters MD (M. D. or other)  
Address 3608 S. Grand Blvd. Date signed 12/1/48

Dr. Walters

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**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 *Harry J. Schumacher*.....  
Licensed Embalmer No. *2679*.....  
P. O. Address *7514 1/2 Broadway*.....

**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.**