

FILED APR 10 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10931

BIRTH NO. _____		REG. DIST. NO. <u>3.7</u>		PRIMARY REG. DIST. NO. <u>6076</u>		Registrar's No. <u>797</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Jennings</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2159	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Elms Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>15 1338-Duke Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Carrie</u> b. (Middle) _____ c. (Last) <u>Spies</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 26, 1951</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never Married</u>		8. DATE OF BIRTH <u>Jan. 12, 1871</u>	
9. AGE (In years last birthday) <u>80</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Spies</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Schaffner</u>		14. NAME OF HUSBAND OR WIFE <u>XXXXXXXXXX</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Al J. LeBeau</u>		ADDRESS <u>#8715-Mavis Pl. St. John-21-Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>MEDICAL CERTIFICATION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Influenza</u>							
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic Cardiovascular disease</u>				5 years			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		481X	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Oct 18, 1949</u> to <u>March 26, 1951</u> , that I last saw the deceased alive on <u>March 20, 1951</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Lewis Littman MD</u>				23b. ADDRESS <u>8231 Clayton Rd</u>		23c. DATE SIGNED <u>3/27/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-29-1951</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Churchyard</u>		24d. LOCATION (City, town, or county) (State) <u>Webster Groves, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3/27/51</u>		REGISTRAR'S SIGNATURE <u>Theobald R. Domke MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Theobald R. Domke MD</u>		ADDRESS <u>2504 Woodson Rd - Overland - 14 - Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10. 484008
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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 3039

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Oscar F. Mueller

Licensed Embalmer No. 3039

P. O. Address Overland 14 Mo.

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.