

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39759

FILED DEC 15 1951

State File No. _____
Registrar's No. **10836**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2269	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Enroute City Hospital		d. STREET ADDRESS (If rural, give location) 26 1908 N. 14th St.	

3. NAME OF DECEASED (Type or Print) a. (First) Charles	b. (Middle)	c. (Last) Spate	4. DATE OF DEATH (Month) (Day) (Year) Dec. 4, 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Feb. 20, 1879	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 12 HRS. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vendor	10b. KIND OF BUSINESS OR INDUSTRY Newspapers	11. BIRTHPLACE (State or foreign country) Unknown	12. CITIZEN OF WHAT COUNTRY? ?
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13a. FATHER'S NAME August Spate	13b. MOTHER'S MAIDEN NAME Elizabeth (Unknown)	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ree Craig	ADDRESS 8818 Springdale
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio and Mitral		
	DUE TO (c) Pneumonia, Chronic		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Interstitial Nephritis			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? 592X
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **7:00 P.** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Patrick C. Taylor Cor 3	23b. ADDRESS 1300 Oak	23c. DATE SIGNED 12.6.51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-7-51	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis, Co., Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE DEC 6 1951 J. Carl Smith, MD	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....
working under my personal supervision.

Student
Student Embalmer

Signed *John S. Pennek*
Licensed Embalmer No. *4194*
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.