

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17704**
Registrar's No. **4964**

FILED JUN 16 1952

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 MO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2039	
d. FULL NAME OF HOSPITAL OR INSTITUTION JEWISH HOSPITAL 3		d. STREET ADDRESS (If rural, give location) 6516 MAURICE	

3. NAME OF DECEASED (Type or Print), a. (First) MELVIN b. (Middle) J. c. (Last) ASPLIN	4. DATE OF DEATH (Month) (Day) (Year) MAY 29 1952
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 14 1892	9. AGE (In years last birthday) 59 if UNDER 1 YEAR Months Days if UNDER 2 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMM. MERCHANT	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) MISSOURI	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME RIONA ASPLIN	13b. MOTHER'S MAIDEN NAME ELYNA BEATTE ESTELLE ASPLIN	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS ESTELLE ASPLIN 6516 MAURICE
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) bilateral pulmonary atalectasis		1 day
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cirrhosis of liver DUE TO (c) atrophic gastritis		unknown unknown
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 543X
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22. I hereby certify that I attended the deceased from **May 16**, 1952, to **May 28**, 1952, that I last saw the deceased alive on **May 28**, 1952, and that death occurred at **4:30 A m.**, from the causes and on the date stated above.

23a. SIGNATURE Samuel Schultz (Degree or title) MD.	23b. ADDRESS 2813 a Watson Blvd.	23c. DATE SIGNED 5/29/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE MAY 31 1952	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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DATE REC'D BY LOCAL REG. MAY 29 1952	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Kutis 2906 Gravois
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Harvard

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.