

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30445

FILED AUG 20 1953

State File No.

7055

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____			
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, Missouri		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) 2269 OR TOWN St. Louis		0			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				d. STREET ADDRESS (If rural, give location) 1920a Benton St.					
3. NAME OF DECEASED (Type or Print) a. (First) FREDERICK		b. (Middle) A		c. (Last) SPIPKER		4. DATE OF DEATH (Month) (Day) (Year) JULY 17, 1953			
5. SEX Male 0		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Mar. 22, 1883			
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 10 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during regular life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) Missouri.			
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME Peter Spilker		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wm. Spilker, 1435 Sullivan Ave.					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANEURYSM OF ASCENDING AORTA ANTECEDENT CAUSES DUE TO (b) LUES. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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) 022X					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 7-13-53, 19 , to 7-17-53, 19 , that I last saw the deceased alive on 7-17-53, 19 , and that death occurred at 11:30A m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Paul H. Larson, M.D.				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 7-17-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 20, 1953		24c. NAME OF CEMETERY OR CREMATORY St. Johns Cem.		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REG. JUL 18 1953		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Leidner Und. Co.		ADDRESS 2223 St. Louis A			

WRITE PLAINLY—USING 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

Gray M. Wilkinson

Licensed Embalmer No. *3575*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.