

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32725**

FILED SEP 28 1954

Hand

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

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| BIRTH NO. _____ | | REG. DIST. NO. 17 | | PRIMARY REG. DIST. NO. 500 | | Registrar's No. 2212 | |
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____ | | | |
| b. CITY OR TOWN Rural Wellston | | c. LENGTH OF STAY (In this place) 2 months | | c. CITY OR TOWN St. Louis | | d. STREET ADDRESS (If rural, give location) 5321 Savoy Court | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Vincent's Hospital | | | | 3. NAME OF DECEASED a. (First) Kate b. (Middle) C. c. (Last) Spain | | | |
| 4. DATE OF DEATH Sept. 18, 1954 | | 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | |
| 8. DATE OF BIRTH Dec. 18, 1861 | | 9. AGE (In years last birthday) 92 | | IF UNDER 1 YEAR Month 7 Days 0 | | IF UNDER 1 MO. Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) M.D. | | 10b. KIND OF BUSINESS OR INDUSTRY M.D. | | 11. BIRTHPLACE (City and State or Foreign Country) Nashville, Tennessee | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13a. FATHER'S NAME John Connell | | 13b. MOTHER'S MAIDEN NAME Annie Tyrall | | 14. NAME OF HUSBAND OR WIFE Walter A. Spain | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none known | | 17. INFORMANT'S SIGNATURE OR NAME Records of St. Vincent's Hospital ADDRESS _____ | | | |
| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility with Dementia | | | | INTERVAL BETWEEN ONSET AND DEATH Years " " | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4200 | |
| 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. HOW DID INJURY OCCUR? _____ | |
| 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"/> | | 22. I hereby certify that I attended the deceased from 7-19-1954 to 9-18-1954 , that I last saw the deceased alive on 9-18-54 , 19 54 , and that death occurred at 5:15 P.M. , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE Joseph A. Costine (Degree or title) M.D. | | 23b. ADDRESS 2407 N. Beverly St. St. Louis | | 23c. DATE SIGNED 9/18/54 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE Sept. 21, 1954 | | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. | |
| DATE REC'D BY LOCAL REG. 9/20/54 | | REGISTRAR'S SIGNATURE [Signature] | | FUNERAL DIRECTOR'S SIGNATURE [Signature] | | ADDRESS 3840 Lindell Blvd. | |

STATEMENT BY LICENSED EMBALMER

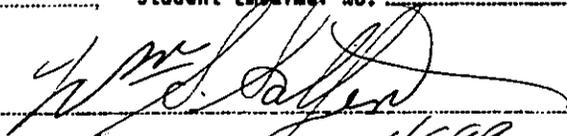
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.