

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38915**  
Registrar's No. **10632**

318 1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		REGISTRAR'S NO. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>21670 16 3523 Connecticut St.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>JOHN</b>		b. (Middle) <b>B.</b>		c. (Last) <b>SPRENKE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 4 1955</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>April 17, 1905</b>	
9. AGE (In years last birthday) <b>50</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant-St. Louis Public Service</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13a. FATHER'S NAME <b>John Sprenke</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Schulte</b>		14. NAME OF HUSBAND OR WIFE <b>Madeline Sprenke</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Madeline Sprenke 3523 Connecticut St.</b>			
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) <b>myocardial failure</b> ANTECEDENT CAUSES DUE TO (b) <b>mitral stenosis</b> DUE TO (c) <b>Rheumatic heart disease</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>410X</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 mos 2</b> <b>2</b>	
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) _____			
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 <b>Sept. 1955</b> , to <b>12-4</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>12-3</b> , 19 <b>55</b> , and that death occurred at <b>2:30A</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Arthur K. Frisep MD.</b>				23b. ADDRESS <b>18 So. Kingshighway</b>		23c. DATE SIGNED <b>12-5-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Dec. 7, 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Ann's Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Normandy, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>DEC 5 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauser 4228 S. Kingshighway Bl.</b>			

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

8, 1911

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Walter A. Sherman*.....

Licensed Embalmer No...45.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.**