ealth,
Welfare
ublic
ervice

300
-57

FILED MAR 19 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-012337
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2844

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 04 BARNES HOSPITAL — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 6073 Wanda — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First CLARENCE	Middle W.	Last SPITZ	4. DATE OF DEATH Month Day Year MARCH 8, 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH Nov 6, 1897
9. AGE (In years last birthday) 80	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) mail carrier	10b. KIND OF BUSINESS OR INDUSTRY retired	11. BIRTHPLACE (City and state or country) Fenton, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Paul Spitz	13b. MOTHER'S MAIDEN NAME Louisa Schlecht	14. NAME OF HUSBAND OR WIFE Rose	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 494-10-8731	17. INFORMANT Rose Spitz	Address 6073 Wanda

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PULMONARY ASTHMA AND EMPHYSEMA — INTERVAL BETWEEN ONSET AND DEATH 15-20 YEARS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 241X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from MARCH 6, 1958, to MARCH 8, 1958 and last saw her/him alive on MARCH 8, 1958

Death occurred at 3:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. C. Vermillion, M.D. M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/9/58
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 3/11/1958	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS J L Ziegenhein & Sons 7027 Gravois	25. DATE RECD. BY LOCAL REG. MAR 11 '58	26. REGISTRAR'S SIGNATURE J Carl Smith MD MKB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. .....

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.