

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011407

STATE FILE NUMBER

2 2203

FILED MAR 17 1959

Registration District No. Primary Registration District No. Registrar

Health, Welfare, Public Service

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56  
2392  
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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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, give TOWNSHIP only) OR TOWN <b>(St. Louis)</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>			Length of stay in lb <b>9-days</b>		d. STREET ADDRESS (If outside, give location) <b>1200 Park Ave.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>G.</b> Last <b>Speisser</b>				4. DATE OF DEATH <b>March 2, 1959</b> Month <b>March</b> Day <b>2</b> Year <b>1959</b>					
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 12, 1870</b>		9. AGE (In years last birthday) <b>88</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-at home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Carlisle, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Unk. Rausch</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. William Speisser, 1200 Park Ave.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of right hip</b> <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>F903.0</b> DUE TO (c) <b>20</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. PLACE AND CIRCUMSTANCES OF DEATH <b>Supposed in fall to sleep at home on February 19</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour <b>2</b> a. m. <b>1959</b> p. m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>232 Home</b>						20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b> COUNTY STATE	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21. I attended the deceased from <b>7:45 A.M.</b> to <b>7:45 P.M.</b> and last saw her/him alive on <b>March 3, 1959</b> Death occurred at <b>7:45 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated						22c. DATE SIGNED <b>3/3/59</b>	
22a. SIGNATURE (Type or print) <b>Robert J. Donnelly</b>		22b. ADDRESS <b>1300 Clark</b>				22c. DATE SIGNED <b>3/3/59</b>			
23a. BURIAL, CREMATION, RECEPTION (Specify) <b>Burial</b>		23b. DATE <b>March 4, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>			
24. FUNERAL DIRECTOR <b>Robert J. Donnelly</b> ADDRESS <b>3840 Lindell Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>MAR 3 '59</b>		26. REGISTRAR'S SIGNATURE <b>Robert Smith, M.D.</b>				

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Francis William*

Licensed Embalmer No. *3*

P. O. Address *3840*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.