

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015766

STATE FILE NUMBER

2 3279

FILED APR 20 1959 Registration District No. Primary Registration District No. Registrar

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wisc.</u> b. COUNTY <u>Rush</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Richland Center</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>De Paul Hosp.</u>		Length of stay in lb <u>2 days</u>	d. STREET ADDRESS (If outside, give location) <u>315 E. Lake Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>HARRY</u> First <u>SPEIDEL</u> Middle <u>W.</u> Last			4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1884</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Druggist Speidel & Speidel</u>		11. BIRTHPLACE (City and state or country) <u>Ladysmith, Wisc.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Steve D. Speidel</u>		13b. MOTHER'S MAIDEN NAME <u>Alice McNamer</u>	
14. NAME OF HUSBAND OR WIFE <u>Daisy Speidel</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>392-32-1505</u>	
17. INFORMANT <u>Daisy Speidel-315 E. Lake Ave. Wisc.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Encephalitis - viral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
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) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>OR 23</u>			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
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 <u>Mar 30, 1959</u> to <u>April 1, 1959</u> and last saw her <u>live</u> on <u>April 1, 1959</u> Death occurred at <u>1247 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert M. Lammich, M.D.</u>			22b. ADDRESS <u>4952 Maryland</u>		22c. DATE SIGNED <u>1 Apr. 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Apr. 1, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rusk County, Wisc.</u>
24. FUNERAL DIRECTOR <u>Pfizinger Mott</u>		ADDRESS <u>Kirkwood 22, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>APR 1 '59</u>	26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

-m 8 B

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 *Ben E Hoffman*

Licensed Embalmer No. *4366*
P. O. Address *St. Louis 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.