

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 29 1960

318

Primary Registration District No.

1003

Registrar's No.

5712

60-024995

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb D.O.A.		c. CITY OR TOWN Jennings		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Jewish Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 7402 Sharon Dr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle Martin Last Speier Sr.				4. DATE OF DEATH Month June Day 2 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 21 April 1915	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Camera Salesman			10b. KIND OF BUSINESS OR INDUSTRY Camera Business		11. BIRTHPLACE (City and state or country) Duluth, Minn.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME DR. Hugo Speier			13b. MOTHER'S MAIDEN NAME Augusta Schmitt			14. NAME OF HUSBAND OR WIFE Mrs Loyola Hogan Speier		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 195-32-3001		17. INFORMANT Mrs. Loyola Speier 7402 Sharon Jennings			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cranial occlusion							10 yrs	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis							10 yrs	
DUE TO (c) Diabetes mellitus							10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260x					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year						
20d. INJURY OCCURRED WHILE AT WORK <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 9-10-51 to 6-2-60 and last saw ^{her} him alive on 5-25-60 Death occurred at 2:30 a m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Mr. Norman Orpel M.D.				22b. ADDRESS 100 North Euclid			22c. DATE SIGNED 6-2-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 6 1960	23c. NAME OF CEMETERY OR CREMATORY National		23d. LOCATION (City, town, or county) Jefferson Barracks Mo.		(State)	
24. FUNERAL DIRECTOR Arthur J. Donnelly 3840 Lindell Blvd				25. DATE RECD. BY LOCAL REG. JUN 3 1960		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed *W. H. [Signature]*
Licensed Embalmer No. 4699
P. O. Address 3840 [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.