

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041415

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10816

STATE FILE NUMBER

DO NOT WRITE ON THIS SUB.

AMENDED

FILED NOV 7 1963

| | | |
|---------------------|--|---------------|
| VS 300 Rev. 4/59 | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF | STATE AMENDED |
| 1 | | |
| 2 <u>20</u> | | |
| 3 | | |
| 4 <u>0</u> | | |
| 5 <u>2</u> | | |
| 6 | | |
| 7 <u>1</u> | | |
| 8 <u>2</u> | | |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 <u>90-0</u> | | |
| 13 | | |
| <u>90</u> | ITEM NO. | SHOULD READ |

BY AFFIDAVIT OF DOCUMENT

| | | | |
|---|---|---|-------------------------------------|
| 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 | | Length of stay in 1b 4 yrs. | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4684a W. Florissant | | c. CITY OR TOWN St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Edward E. Espenschied | | 4. DATE OF DEATH Month Day Year 10 30 63 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/19/89 |
| 9. AGE (last birthday) 73 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sta. Engineer - Ret. | |
| 11. BIRTHPLACE (City and state or country) Alhambra, Ill. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Phillip Espenschied | | 13b. MOTHER'S MAIDEN NAME Sophie Moeller | |
| 14. NAME OF HUSBAND OR WIFE Irene Turley Espenschied | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address 4684a W. Florissant Miss Janet Espenschied | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interruption Heart due to DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 420.0 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus Chas | | | |
| 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 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.) | |
| 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 9/16/49 to 10/30/63 and last saw her/him alive on 4/11/63 Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Robert Warner M.D. (Degree or title) | | 22b. ADDRESS 1165 Paul Brown Bldg of Lind | |
| 22c. DATE SIGNED Oct 31 63 | | 23. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 11/2/63 | |
| 23c. LOCATION (City, town, or county) St. Louis County Mo. | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral 1905 Union | | 25. DATE RECD. BY LOCAL REG. OCT 31 1963 | |
| 26. REGISTRAR'S SIGNATURE Roan Smith, M.D. | | | |

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Robert G. Warner
Paul Brown Bldg.
Ch. 1-4747

Hrs. 12 - 4 PM Thurs. & Fri.

9-28

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 Warren A. Carver
Licensed Embalmer No. 3538

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.