

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

586

Do not use this space.

586

1. PLACE OF DEATH

(a) County Registration District No. 1003
(b) Township Primary Registration District No. Registered No.
(c) City St. Louis / (d) Street No. City Hospital No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D. 13886 21/2 (Rubie) Ruben Nickles

2. PRINT FULL NAME
(a) Residence, No. 1315 South 6th [23] (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 30, 1879

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
59 -- 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. turnkey
9. Industry or business in which work was done, as saw mill, bank, etc. nil
10. Date deceased last worked at this occupation (month and year) unknown 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri

FATHER 13. NAME Jacob Nickles

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

MOTHER 15. MAIDEN NAME Jane Walters

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

17. INFORMANT Hosp. Info M. Kent
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Park Lawn Cemetery DATE 1/20/39 19.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Oscar J. Hoffmeister
4016 Chippewa St.

20. FILED JAN 19 1939 J. B. Budick
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/18/39 19

22. I HEREBY CERTIFY, That I attended deceased from 12/23/38 to 1/18/39, 19.....

I last saw him alive on 1/18/39, 19..... Death is said

to have occurred on the date stated above, at 1 p.m.

The principal cause of death and related causes of importance were as follows:

Carcinoma of Small Intestine Date of onset

Hypertension

Other contributory causes of importance:

Name of operation Hysterectomy Date of 1-24-39

What test confirmed diagnosis? his Was there an autopsy? his

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury....., 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) J. B. Budick M. D.

(Address) City Hospital No. 1

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Edwin H. Leisinger

Licensed Embalmer No.....

4049

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 this body is not embalmed, above space should be left blank.