N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D FEB 10 1939

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

717
Do not use this space.

791

1. PLACE OF DEATH
(a) County ..... Registration District No. 1003
(b) Township ..... Primary Registration District No. ..... Registered No. 717
(c) City ST. LOUIS (d) Street No. CITY HOSPITAL #I 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.

2. PRINT FULL NAME 2112 WILLIAM NICKLES
(a) Residence, No. 1324 SO. SIXTH ST. St. 23
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) WIDOWED
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF HARNETTE NICKLES
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 13, 1866
7. AGE YEARS 72 MONTHS 5 DAYS 9 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. NIGHT WATCHMAN
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) JAN. 1, 1929
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ST. LOUIS MO.

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 (ADDRESS) Mrs. Ruth Larrabee 4958 Tholozan
18. BURIAL, CREMATION, OR REMOVAL
PLACE PARKLAWN CEMETERY DATE 1/25/39 19
19. FUNERAL DIRECTOR (NAME) (ADDRESS) OSCAR J. HOFFMEISTER 4016 CHIPPEWA ST.
20. FILED JAN 24 1939 J. F. Budrick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 22nd, 19 39
22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at 12:10 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage;	
Arteriosclerosis.	

Other contributory causes of importance: 82

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

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 see above
Nature of injury No

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Joseph M. Lennon, M. D.
(Address) Deputy Coroner

(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 embalmed by me, ...

....., or by .....

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

Signed Edwin H. Lechinger

Licensed Embalmer No. 4049

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

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