

11-10-39
5-17-39
X21492

940

FILED FEB 7

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3855

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 128

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Wellston

(c) Name of hospital or institution:
6325 Wellsmar Ave.

(d) Length of stay: In hospital or institution _____

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Wellston

(d) Street No. 6325 Wellsmar Ave.

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Alice Nehrt

3. (b) If veteran, name war No. _____

3. (c) Social Security No. No.

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emil

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased March 18 1894

8. AGE:

Years	Months	Days	If less than one day
<u>45</u>	<u>9</u>	<u>29</u>	hr. _____ min. _____

9. Birthplace Addieville Illinois

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {

12. Name Fred Heminghaus

13. Birthplace St. Louis Missouri

14. Maiden name Emma Meyer

15. Birthplace St. Louis Missouri

16. (a) Informant Emil Nehrt

(b) Address 6325 Wellsmar Ave.

17. (a) Removal (b) Date thereof 1/19/40

(c) Place: burial or cremation Nashville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4200 Washington Ave.

19. (a) JAN 18 1940 (b) [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan 16th, day _____, year 1940, hour 7, minute P.

21. I hereby certify that I attended the deceased from 12/26/39 to 1/16/40

that I last saw her alive on Jan 16th 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Embolism

Duration 15 minutes

Due to Head Injury (Sub Dural Hematoma) Fracture 5th & 6th Ribs - R. Side

Due to Auto accident 12/26/39 Oak Bottom Road, Illinois

Other conditions _____

PHYSICIAN

Major findings: No fracture

Of operations _____

Of autopsy none

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Auto Acc above

(b) Date of occurrence 12/26/39

(c) Where did injury occur? Oak Bottom Road, Ill.

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway

While at work? no (e) Means of injury Auto Accident

23. Signature Frank L. Davis (M. D. _____)

Address University Club Bldg Date signed 1/18/40

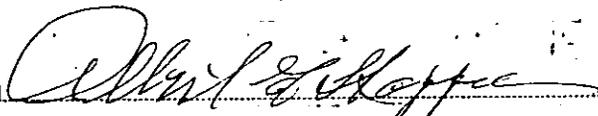
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

210 m
9/9

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



Licensed Embalmer No. 2971

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3853-7
Registrar's No. 126

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 784

Primary Registration District No. 200

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County St. Louis
(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Alice Nehrl

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 45 Months 9 Days 29 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-18-40 (b) [Signature] (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Pulmonary Embolism

Due to Head injury (Dist. Skull Hemorrhage)

Due to Fracture 5 and 6 ribs R side

Other conditions Auto accident 12/26/39 (Include pregnancy within 3 months of death)

Major findings: See in road, auto thrown down grade sidewalk, striking head on pier post. Cerebral hemorrhage - lat. - extension

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically!

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence Jan 16 1940
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Frank L Davis (M. D. or other) _____
Address University City Date signed _____

SUPPLEMENTARY

152

