

Registration District No. **791**

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County St. Louis Mo. **1**  
(b) City or town St. Louis Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Missouri Pacific Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 months  
(Specify whether  
In this community Life  
years, months or days)

8. (a) PRINT FULL NAME HENRY SAMUEL NIRK **67**

8. (b) If veteran, name war none 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Elda Kestner Nirk 6. (c) Age of husband or wife if alive 6 years

7. Birth date of deceased Feb. **1862**  
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 3 If less than one day hr. min.

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired R.R. Engineer **0**

11. Industry or business Missouri Pacific R.R. **0**

12. Name William Nirk **1**

13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name not known **93**

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

16. (a) Informant Harace Nirk

(b) Address 4210 Neosho

17. (a) Burial (b) Date thereof May 13, 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Wm S Ziegenhain & Sons

(b) Address 7027 Gravois Ave.

19. (a) MAY 10 1940 (b) J. J. [Signature]  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town Saint Louis **2**  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5821 Gravois Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 9<sup>th</sup>  
year 1940 hour 4:57 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from February 28<sup>th</sup>, 1940 to May 9<sup>th</sup>, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Chronic myocarditis decompen-  
sated  
arteriosclerosis, general  
Chronic hypertrophy of prostate  
Chronic cystitis  
Inguinal hernia, bilateral

Other conditions (Include pregnancy within months of death)  
Cataracts, bilateral  
Major findings: non catarhal  
Of operations non gonorrhoeic  
Of autopsy non tubercular

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 Illness  
(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 Malvont Bryan (M. D. or nurse)  
Address Mo. Pac. Hosp., St. Louis Date signed 5/10/40

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

**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

*C. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address *4930<sup>2</sup> Robert*

**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.**