No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23937

FILED AUG 25 1940

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 6382

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

1. PLACE OF DEATH:

(a) County

(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: DE PAUL HOSPITAL 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 26 HOURS (Specify whether years, months or days)

In this community LIFE

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3. (a) PRINT FULL NAME THOMAS. CARROLL NUENING

3. (b) If veteran, name war NONE

3. (c) Social Security No. 489-09-6035

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased SEPT. (Month) 22 (Day) 1917 (Year)

8. AGE:

Years	Months	Days	If less than one day
22	10	6	— hr. — min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country) 0

10. Usual occupation GROCERY CLERK 0

11. Industry or business FATHERS STORE 0

FATHER
12. Name JOSEPH J. NUENING
13. Birthplace ST. LOUIS (City, town, or county) MO. (State or foreign country)

MOTHER
14. Maiden name JOHANNA T. CARROLL
15. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)

16. (a) Informant J. Nuening
(b) Address 1600 A. N. 18TH STR

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 30=1940 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Brookland Und Co
(b) Address 1827 HOGAN STR.

19. (a) JUL 29 1940 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County

(c) City or town ST. LOUIS. 26
(If outside city or town limits, write "RURAL")

(d) Street No. 1600 A. N. 18TH STR. 0
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 28TH year 1940 hour 2:30 minute A. M.

21. I hereby certify that I attended the deceased from 7/25th, 1940, to 7/28, 1940, that I last saw him alive on 7/27th 1940, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia Lobar	
Due to: Septic Pharyngitis, non diphtheritic	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy no	

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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

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature James A. Sullivan (M. D. or other)

Address 2864 N Union Bl Date signed 7/28/40.

(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 Albert S. Hopper

Licensed Embalmer No. 2971

P. O. Address _____

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

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