

FILED JAN 25 1945

State File No. ....

Registration District No. 318

Primary Registration District No. 100

Registrar's No. 444

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Alexian Brothers Hosp.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 7 days  
 (Specify whether  
 In this community  
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County oao  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 8114 Pennsylvania Ave.  
 (If rural, give location) 17  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME Bert O. Nessler

3. (b) If veteran, name war ..... 3. (c) Social Security No. 492-12-2915

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

6. (b) Name of husband or wife Clara B. 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Nov. 22 1885  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>1</u>	<u>23</u>	.....hr. ....min.

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

10. Usual occupation Serviceman

11. Industry or business Gate Motor Co.

MOTHER FATHER {  
 12. Name Unknown  
 13. Birthplace Unknown  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Oliver H. Bohres  
 (b) Address 7604 Williams R. H.

17. (a) Burial (b) Date thereof Jan. 17, 1945  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus Cem.  
 18. (a) Signature of funeral director Wacker Hellerle  
 (b) Address 8634 Gravois Ave.

19. (a) JAN 16 1945 (b) J. J. Bredeck  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 14  
 1945 year. hour 10 minute 55 A.M.

21. I hereby certify that I attended the deceased from 1/8 1945 to 1/14 1945;  
 that I last saw him alive on 1/14 1945;  
 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage (left) Hemiplegia 7 days

Due to .....  
 Due to .....  
 Other conditions (Include pregnancy within 3 months of death) SB

Major findings:  
 Of operations none  
 Of autopsy none

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) none  
 (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? .....

While at work? (Specify type of place) (e) Means of injury 0

23. Signature E. F. Lassin (M. D. or other) 0  
 Address Francis Bely Date signed 1/15/45

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 Robert Wheeler

Licensed Embalmer No. 2178

P. O. Address St Louis Mo

**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, fact should be so stated above.**