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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED FEB 13 1945

Registration District No. 376

Primary Registration District No. 6076

Registrar's No. 2865

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Manchester  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Pine Crest Homes for Aged  
(If not in hospital or institution, write street number or location) 5

(d) Length of stay: In hospital or institution 2 Mo. (Specify whether)

In this community Yes years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 066

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17

(d) Street No. 4144 Westminster Ave (If rural, give location) 9

(e) Citizen of foreign country? (Yes or No) 1  
If yes, name country

3. (a) PRINT FULL NAME John Nichols

3. (b) If veteran, name war  
3. (c) Social Security No. 702-14-7015

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W 1

6. (b) Name of husband or wife Anna Nicholas 6. (c) Age of husband or wife if alive 2 years

7. Birth date of deceased June 22 - 1869  
(Month) (Day) (Year)

8. AGE: Years 75 Months 7 Days = If less than one day hr. min.

9. Birthplace Shannon Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business Unknown

12. Name James Nicholas

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 Oscar Nicholas

(b) Address 4170 1/2 Levee St. Louis MO

17. (a) Burial (b) Date thereof 1-24-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Poplar Bluff MO

18. (a) Signature of funeral director Garis A Hoff  
(b) Address Herkwood Mo

19. (a) JAN 24 1945 (b) Carl McGarratt  
(Date received local report) (Registrar's signature) (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 22  
year 1945 hour 8 minute A M.

21. I hereby certify that I attended the deceased from Nov 23 19 45 to Jan 22nd 19 45.

that I last saw him alive on Jan 2nd 19 45 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Arterio Sclerosis  
Of operation

Of autopsy 438

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?

While at work? (Specify type of place) (e) Means of injury 3

23. Signature R. W. Jansen (M. D. or other)

Address Manchester Mo Date signed 1/22/45

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

FEB 16 1945

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 *Felix Aliand*.....

Licensed Embalmer No. *3034*.....

P. O. Address *Kirkwood 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.