

S. No. 2
M-5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 3 1945
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

11602
State File No. _____
Registrar's No. **3590**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4546 Labadie Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution None
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Dr. Charles W. Nehl
3. (b) If veteran, name war None
3. (c) Social Security No. _____

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Anna Nehl nee Lee
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 11, 1870
(Month) (Day) (Year)

8. AGE: Years 75 Months 1 Days 11
If less than one day hr. _____ min. _____

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

10. Usual occupation Physician

11. Industry or business _____

12. Name Charles W. Nehl Sr.

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

14. Maiden name Anna Wagner

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

16. (a) Informant Mrs Huldah Murray
(b) Address 4546 Labadie Ave

17. (a) Burial (b) Date thereof 4/24/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) APR 23 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4546 Labadie Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22,
year 1945 hour 5:15 AM minute _____ M.

21. I hereby certify that I attended the deceased from Mar 25, 1945, to Apr 22, 1945
that I last saw him alive on Apr 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Duration _____

Due to Arteriosclerosis
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____

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 _____

23. Signature [Signature] (M. D. or other) MD
Address 4943 St. Clair Date signed 4/23/45

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.....

Licensed Embalmer No.....

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, fact should be so stated above.