S. No. 2
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. 5-17-39
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39246

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 28 1945

State File No. 29289

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8148

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: St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3mos-10 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000

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

(d) Street No. 6307 ARSENAL ST 9 3
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Joseph Nagle

3. (b) If veteran, name war ✓

3. (c) Social Security No. 491-16-5103

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased July 8 (Month) (Day) (Year)

8. AGE: Years 54 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business SALESMAN

FATHER
12. Name PIERRIE NAGLE
13. Birthplace — (City, town, or county) IRELAND 4 (State or foreign country)

MOTHER
14. Maiden name ISBABEL MUSIC
15. Birthplace FLORRISANT (City, town, or county) Mo (State or foreign country)

16. (a) Informant VIRGINIA KUENKEI
(b) Address 5329 N. EUCLID AV.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 - - 1945 (Month) (Day) (Year)
(c) Place: burial or cremation CALVERY CEM.

18. (a) Signature of funeral director HOWARD F. ROWLAND
(b) Address 4355 WASHINGTON AV.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17th year 1945 hour 2:08 minute PM M.

21. I hereby certify that I attended the deceased from 6/7/45, 19, to 9/17/45, 19; that I last saw him alive on 9/17/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate with metastasis

~~Due to~~ Pathological fracture - rt femur

Due to

Other conditions (Include pregnancy within 3 months of death) 51 b

Major findings:
Of operations
Of autopsy

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

(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 N J Bublis (M. D. or ~~other~~)

Address 1515 Lafayette Date signed 9/17/45

(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 Ronald Yahnke

Licensed Embalmer No. 3917

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.