

S. No. 2
M-8-43
S-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34469**
Registrar's No. **150**

Registration District No. **310** Primary Registration District No. **3058**

1. PLACE OF DEATH:
(a) County **St. Charles**
(b) City or town **St. Charles**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Joseph Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 days**
(Specify whether
In this community **50 years**
years, months or days)

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

3. (a) PRINT FULL NAME **Rudolph Nestel**
(b) If veteran, name war **no**
(c) Social Security No. **no**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** 1945 year **1945** hour **12** minute **30** A.M.
21. I hereby certify that I attended the deceased from **September 9**, 1945 to **Oct 12**, 1945
that I last saw him alive on **Oct 11**, 1945
and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **single**
(b) Name of husband or wife **none**
(c) Age of husband or wife if alive _____ years
7. Birth date of deceased **April 17 1865**
(Month) (Day) (Year)

Immediate cause of death **Uraemia**
Due to **arteriosclerosis - hypertension**
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy **97**

8. AGE: Years Months Days If less than one day
80 5 25 hr. _____ min.
9. Birthplace **Germany**
(City, town, or county) (State or foreign country)

10. Usual occupation **farm laborer**
11. Industry or business _____
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)

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 _____

16. (a) Informant **Information from Social Security Office**
(b) Address **St. Charles, Mo.**
17. (a) **Burial** (b) Date thereof **10-15-45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Peters, Mo.**
18. (a) Signature of funeral director **Geo. Steffner**
(b) Address **St. Peters, Mo.**
19. (a) **10/15/45** (b) **Samuel Paul**
(Date received local registrar) (Registrar's signature)

23. Signature **Wm. A. Schmitt** (M. D. or other) **W.D.**
Address **St. Charles, Mo.** Date signed **10/12/45**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 11-14-45

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.....

E. Keithly

Licensed Embalmer No. 872

P. O. Address.....

Fallon 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.