

FILED NOV 17 1945

Primary Registration District No. **3063**

Registrar's No. **2568**

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

1. PLACE OF DEATH:

(a) County **St Louis**
(b) City or town **Clayton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **St Louis County Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether
In this community **8 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St Louis 96**
(c) City or town **Kelwood 4**
(If outside city or town limits, write "RURAL")
(d) Street No. **Old Falls Home 3**
(If rural, give location)
(e) Citizen of foreign country? **1**
If yes, name country _____ (Specify No.)

3. (a) PRINT FULL NAME **Nicholson, Mae**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **5** **1865**
(Month) (Day) (Year)

8. AGE: Years **80** Months **6** Days **6** If less than one day hr. _____ min. _____

9. Birthplace **New York N.Y.**
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business **none**

MOTHER FATHER

12. Name **Mrs Nicholson**

13. Birthplace **unknown 9**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret 9**

15. Birthplace **unknown 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Eckhardt**

(b) Address **Old Falls Home Kelwood**

17. (a) **Burial** (b) Date thereof **11-9-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cem**

18. (a) Signature of general director **Louis H. Bass**

(b) Address **St Louis MO**

19. (a) **11-10-45** (b) **G. B. Saran**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **11** day **7**
year **1945** hour **11** minute **30 A** M.

21. I hereby certify that I attended the deceased from **Nov 2**, 19**45** to **Nov 7**, 19**45**
that I last saw her alive on **11-7-1945**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Pleurisy with effusion 2 wks**

Due to **1108**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

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? _____

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

23. Signature **Wm W. Castle** (M. D. or other) **MD**
Address **601 Chestnut** Date signed **11/7/45**

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.....

Felix Howard

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.