S. No. 2
M—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 28 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 39581

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10888

1. PLACE OF DEATH:

(a) County

(b) City or town Saint Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4716 Pennsylvania Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution / (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County 15

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

(d) Street No. 4716 Pennsylvania Ave.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME John Nacke.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Amalia Nacke.

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

7. Birth date of deceased October (Month) 25th, (Day) 1876. (Year)

8. AGE: Years 69 Months 1 Days 18 If less than one day hr. min.

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

10. Usual occupation Laborer Park Department

11. Industry or business

FATHER
12. Name ? Nacke
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Joseph Reining
(b) Address 3624 Alberta Street.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof Dec. 15, 1945. (Month) (Day) (Year)
(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Ziegenhein Bros.
(b) Address 6409 Gravois Ave.

19. (a) DEC 14 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 13th, year 1945. hour 6 minute 15 A. M.

21. I hereby certify that I attended the deceased from 7-11-44, 19..., to 12-13, 1945; that I last saw him alive on 12-12, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic nephritis	13 mon
Due to: Fibrillation	13 mon
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 John D. Sent M.D. (M. D. or other)
Address 2840 California Date signed 12-14-45

(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 Homer W. Fritz

Licensed Embalmer No. 3882

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.