

No. 2
DM-5-43
v. 5
I X36671

FILED DEC 28 1945
318

Registration District No. Primary Registration District No. 1003 Registrar's No. 11032

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis Missouri
(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
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 years
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis
(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 WILLIAM NICHOLS

3. (b) If veteran, none name war _____
 3. (c) Social Security none No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12-16-45 day _____
 year _____ hour 7:30 PM minute _____ M. _____

4. Sex Male White 5. Color race _____
 6. (a) Single widowed, married, divorced _____
 6. (b) Name of husband or wife Mary 6. (c) Age of husband or wife if _____
 7. Birth date of deceased Oct. 16 1873
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 10-22-45 19____ to 12-16-45 19____
 that I last saw him alive on 12-16-45 19____
 and that death occurred on the date and hour stated above.

8. AGE: Years 72 Months 2 Days 0 If less than one day _____
hr. min.

Immediate cause of death Carcinoma of esophagus with tracheo-esophageal fistula
 Due to _____

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

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

10. Usual occupation Unemployed
 11. Industry or business none

PHYSICIAN

Major findings: As above
 Of operations _____
 Of autopsy As above

MOTHER FATHER

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? _____

16. (a) Informant Cecelia Zoll
 (b) Address 10,122 Niblic Dr. Overland
 17. (a) Burial (b) Date thereof 12-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Bethany Cemetery

While at work? _____
(Specify type of place) (e) Means of injury _____
 23. Signature J. F. Bredich (M. D. or other) _____
 Address 1515 Lafayette Ave

18. (a) Signature of funeral director J. F. Bredich
 (b) Address 2504 Woodson Rd. Overland
 19. (a) DEC 18 1945
(Date of local registration) (Registrar's signature)

12-17-45

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 Harold K. Braun

Licensed Embalmer No. 4337

P. O. Address: Overland, Ind.

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.