

S. No. 2  
OM-5-43  
v. 5-17-39  
I X38571

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
**FILED** MAR 20 1946 **STANDARD CERTIFICATE OF DEATH**

State File No. **11488**  
Registrar's No. **2423**

Registration District No. **318** Primary Registration District No. **1003**

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

**1. PLACE OF DEATH:**  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Mo. Baptist Hospital  
(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 Warren **109**  
(c) City or town Wright City  
(If outside city or town limits, write "RURAL") **1 N.R.**  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Daniel Webster Nance  
3. (b) If veteran, name war No 3. (c) Social Security No. None

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month March day 10  
year 1946 hour 7 minute 2 M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower  
6. (b) Name of husband or wife Rachel Ann Nance 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 4 1872  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Feb 25, 1946, to March 10, 1946;  
that I last saw him alive on March 9, 1946;  
and that death occurred on the date and hour stated above.

**8. AGE:** Years Months Days If less than one day  
73 11 6 hr. min.

Immediate cause of death Myocarditis **2 wks**  
Due to R. Hydronephrosis **5 years**

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

Other conditions (Include pregnancy within 3 months of death) 92

**10. Usual occupation** Retired Carpenter  
**11. Industry or business**  
12. Name Unknown  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

**Major findings:**  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Florence Poston  
(b) Address 6450 Clemens Ave.  
17. (a) Burial (b) Date thereof 3-13-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Valhalla Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Albert H. Hoppe  
(b) Address 4700 Washington Blyd.  
19. (a) MAR 12 1946 (b) J. F. Biedeck  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature Joseph E. Glenn (M. D. 1938)  
Address 1958 Arcade Bldg Date signed 3/12/46

MAR 22 1945

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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.....

*Henry M. Brammer*

Licensed Embalmer No..... *4200* .....

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.