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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 28 1946

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 34673

Registration District No. 317 Primary Registration District No. 3069 Registrar's No. 3127

**1. PLACE OF DEATH:**

(a) County St. Louis,

(b) City or town Richmond Heights, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
7413 Arlington Dr.
(If not in hospital or institution, write street number or location)

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

In this community

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 96

(c) City or town Richmond Heights 8
(If outside city or town limits, write "RURAL")

(d) Street No. 7413 Arlington Dr. 3
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME Thomas Nestor

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 Catherine

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

7. Birth date of deceased March 25, 1865
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 6 | 15. | hr. min. |

9. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

10. Usual occupation Nil

11. Industry or business

FATHER
12. Name Martin Nestor
13. Birthplace Ireland 7
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Ellen Kealey
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Ellen Wright
(b) Address 7413 Arlington Dr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/46 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Edith E. Ambruster
(b) Address 4234 Manchester

19. (a) 10-24-46 (Date received local registrar) Ruth Jellenik (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct. day 20 year 1946 hour 3.45 P.M. minute M.

21. I hereby certify that I attended the deceased from March 12, 1942, to Oct. 20, 1946 that I last saw him alive on October 10, 1946 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Chr. Myocarditis | |
| Due to: Partial bowl obstruction | |
| Due to: Ventral Herniae | |
| Other conditions: Malnutrition (Include pregnancy within 3 months of death) | |

Major findings:
Of operations: no
Of autopsy: no

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) no

(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)

(e) Means of injury

While at work?

23. Signature James [illegible] M.D.

Address 634 North Grand Date signed 10/21/4

(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.....

Licensed Embalmer No. 1284

P. O. Address St.Louis,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.**