

FILED JAN 10 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

43197

State File No. _____
 Registrar's No. **04781**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **6076**

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

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL, and give township) Glendale		c. CITY (If outside corporate limits, write RURAL and give township): Glendale 22	
c. LENGTH OF STAY (in this place) 5 YRS		d. STREET ADDRESS (If rural, give location) 1055 GLENMOOR 10	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1055 GLENMOOR			

3. NAME OF DECEASED (Type or Print) a. (First) Lee b. (Middle) JOHN c. (Last) NYHOF	4. DATE OF DEATH (Month) (Day) (Year) 12 26 1949
---	--

5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) III	8. DATE OF BIRTH 10-30-1904	9. AGE (In years last birthday) Months Days 45 1 16	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER	11. BIRTHPLACE (State or foreign country) St Louis Mo	12. CITIZEN OF WHAT COUNTRY? USA
-----------------	---------------------------	---	---------------------------------------	---	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER	10b. KIND OF BUSINESS OR INDUSTRY BOWLING ALLEY	11. BIRTHPLACE (State or foreign country) St Louis Mo	12. CITIZEN OF WHAT COUNTRY? USA
---	---	---	--

13a. FATHER'S NAME ANTHONY NYHOF	13b. MOTHER'S MAIDEN NAME SADIE OXMAN NYHOF	14. NAME OF HUSBAND OR WIFE Gene Oak Nyhof
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 497-07-9317	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gene Nyhof 1055 Glenmoor Glendale 22 Mo
---	---	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis Heart disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) (Wield with Coronary occlusion due to I) DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		420.1	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from **12/26, 1949** to **6 am**, 19**49**, that I last saw the deceased alive on **December 19**, and that death occurred at **5:45 am.**, from the causes and on the date stated above.

23a. SIGNATURE C. F. Caravelli MD	23b. ADDRESS 634 No. Grand Blvd	23c. DATE SIGNED 12/26/49
---	---	-------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-28-49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Mo
--	------------------------------	---	---

DATE REC'D BY LOCAL REG. 12-27-49	REGISTRAR'S SIGNATURE Herbert R. Donke, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MITTELBERG FUN. HOME
---	--	---

497-07-9317
see page

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Albert G. Rapp

Licensed Embalmer No. 2971

P. O. Address St. Louis

25
1749
Andee

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.