

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3556**
Registrar's No. **1127**

FILED FEB 11 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE **Missouri** b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Saint Louis** c. LENGTH OF STAY (in this place) **5 1/2 Weeks**
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **Saint Louis** **2079**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Christian Hospital** d. STREET ADDRESS (If rural, give location) **4919 San Francisco Avenue, 15,**

3. NAME OF DECEASED a. (First) **HENRY** b. (Middle) **J.** c. (Last) **NOLLMANN** 4. DATE OF DEATH (Month) (Day) (Year) **Jan. 29th, 1953**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married** 8. DATE OF BIRTH **Aug. 11th, 1869** 9. AGE (In years last birthday) **83** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired Hdwe. Dealer** 10b. KIND OF BUSINESS OR INDUSTRY **Hardware** 11. BIRTHPLACE (City and State or Foreign Country) **St. Charles, Missouri** 12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **Fred Wm. Nollmann** 13b. MOTHER'S MAIDEN NAME **Betty Lindemann** 14. NAME OF HUSBAND OR WIFE **Katie M. Nollmann nee Reifeis**

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. **None** 17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Katie M. Nollmann, 4919 San Francisco Avenue**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Carcinoma of prostate**
INTERVAL BETWEEN ONSET AND DEATH **12 years**
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES
Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? **177X**

22. I hereby certify that I attended the deceased from **1-16-1940**, 19____, to **1-28-53**, 19____, that I last saw the deceased alive on **1-28-53**, 19____, and that death occurred at **6:55A** m., from the causes and on the date stated above.

23a. SIGNATURE **[Signature]** (Degree or title) **M.D.** 23b. ADDRESS **607 N. Grand, St. Louis 3, Mo.** 23c. DATE SIGNED **1-30-53**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **1/31/53** 24c. NAME OF CEMETERY OR CREMATORY **Memorial Park Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis County, Missouri**

DATE REC'D BY LOCAL REG. **JAN 30 1953** REGISTRAR'S SIGNATURE **[Signature]** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Calvin F. Feutz, 4828 Natural Bridge Blvd.**

(Licensed Embalmer's Statement on Reverse Side)

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

Hours: Between 2:00 PM & 4:00 PM.
(FRIDAY SURE)

No hours on Thursdays

FILE IN CITY.

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 *John A. Melisar*

Licensed Embalmer No. *4186*

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.