

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED OCT 23 1953

State File No. **37602**  
Registrar's No. **9815**

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 <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo</b>		c. CITY OR TOWN <b>St. Louis, Mo</b>	
c. LENGTH OF STAY (In this place) <b>40 yrs.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>5400 Arsenal St.</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>ALVINA</b>		c. (Last) <b>SINZ</b>	
b. (Middle)		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 13, 1953</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <b>Divorced</b>	8. DATE OF BIRTH <b>April 1, 1869</b>
9. AGE (In years last birthday) <b>84</b>		10. UNDER 1 YEAR Months	11. UNDER 2 RES. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Joseph Nuelle</b>		13b. MOTHER'S MAIDEN NAME <b>Mary</b>	
14. NAME OF HUSBAND OR WIFE			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>William J. Sinz</b>	ADDRESS <b>4000 Walsh, St. Louis, Mo.</b>
--	-------------------------	--	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrsx</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Generalized Arteriosclerosis</b>		DUPLICATE TO (b) <b>Arteriosclerotic heart disease</b>		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE 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 <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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4200</b>
--	--	--

22. I hereby certify that I attended the deceased from **Jan. 1, 1948**, to **Oct. 13, 1953**, that I last saw the deceased alive on **Oct. 13, 1953**, and that death occurred at **7:15a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>John H. McLaughlin MD</b>	23b. ADDRESS <b>5400 Arsenal St.</b>	23c. DATE SIGNED <b>10/13/53</b>
---	--------------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	24b. DATE <b>10-16-1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
--	-----------------------------	--	--

DATE REC'D BY LOCAL REG. <b>OCT 14 1953</b>	REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>McLaughlin's</b>	ADDRESS <b>2301 Lafayette, St. Louis, Mo.</b>
---	--	--	---

---

---

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

*James R. Chapman*  
Licensed Embalmer No. 4  
P. O. Address *St. L.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.