

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

31805

State File No. ....

FILED OCT 1 - 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 231

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

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Charles</u>		c. CITY OR TOWN <u>St. Charles</u>	d. Is Residence within limits of a city or incorporating town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Hill Side Rest Home</u>		e. STREET ADDRESS (If rural, give location) <u>Route # 4</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>CATHERINE</u> b. (Middle) _____ c. (Last) <u>NOLLE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 21, 1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 6, 1871</u>
9. AGE (In years last birthday) <u>85</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Decatur, Illinois</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
13a. FATHER'S NAME <u>Thomas Lewis</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>John Henry Nolle</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clifton Nolle, St. Charles, Mo.</u>
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CHRONIC PULMONARY CONGESTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE 10 YRS.</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>GENERALIZED ARTERIOSCLEROSIS 15 YRS.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>H 200</u>	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)		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 <u>Aug. 6, 1955</u> , to <u>Sept. 21, 1956</u> , that I last saw the deceased alive on <u>Sept. 21, 1956</u> , and that death occurred at <u>7:45 P. m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Paul H. Kother</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>St. Charles, Mo.</u>	23c. DATE SIGNED <u>9/24/56</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept. 24, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemet.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Charles, Mo.</u>
DATE REC'D BY LOCAL REG. <u>Sept 24 1956</u>		REGISTRAR'S SIGNATURE <u>Hannie Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur C. Bone, Jr., Charles, Mo.</u>

**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.....  
Signature of Student Embalmer

Signed *Clarence M. Bille*.....

Licensed Embalmer No. *4375*.....

P. O. Address *Dr. Charles M.*.....

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 embalmed by a **STUDENT**, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.