

Health & Welfare  
Public Health Service

S. 300  
Y. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38569

STATE FILE NUMBER

FILED OCT 16 1957

Registration District No. 312 Primary Registration District No. 546 Registrar's No. 2415

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Overland City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Overland City</u> <u>423x</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9620 Holtwood ave</u>			Length of stay in 1b <u>years</u>		d. STREET ADDRESS (If outside, give location) <u>9620 Holtwood ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>NELS CHRISTENSEN</u>				First		Middle		Last	
4. DATE OF DEATH <u>Sept 29, 1957</u>				Month		Day		Year	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26,</u>		9. AGE (In years last birthday) <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoemaker</u>		11. BIRTHPLACE (City and state or country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>unk Christensen</u>				14. MOTHER'S MAIDEN NAME <u>unk</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>	
16. SOCIAL SECURITY NO. <u>latez</u>				17. INFORMANT <u>Mrs. Amanda Christensen</u>				Address <u>Overland Mo. 9620 Holtwood ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma of brain</u> DUE TO (b) <u>Adenocarcinoma of ampulla</u> DUE TO (c) <u>of Vater</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1552</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 yrs</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. - p. m. Month, Day, Year									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>1953</u> to <u>9-29-57</u> and last saw her/him alive on <u>9-26-57</u> Death occurred at <u>12:15</u> <u>A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>V.O. Fish M.D.</u> (Degree or title)				22b. ADDRESS <u>634 N. Grand St. St. Louis</u>				22c. DATE SIGNED <u>9-30-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>Oct. 1, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri.</u>			
24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons</u> ADDRESS <u>7233 Delmar Blv'd.</u>				25. DATE RECD. BY LOCAL REG. <u>10-1-57</u>		26. REGISTRAR'S SIGNATURE <u>Robert B. Donahue</u>			

1-5 PM

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 H. Murray*

Licensed Embalmer No. *407*

P. O. Address *St. Louis*

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.