

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 2 - 1957

STATE FILE NUMBER
1286

Registration District No. 42 Primary Registration District No. 1000 Registrar's No.

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 413 Ohio		d. STREET ADDRESS (If outside, give location) 6035 Gordon	
3. NAME OF DECEASED (Type or print) First Middle Last John F Nerka		4. DATE OF DEATH Month Day Year Nov. 19, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern operator		10b. KIND OF BUSINESS OR INDUSTRY Tavern	11. BIRTHPLACE (City and state or country) Poland
13a. FATHER'S NAME Unk		13b. MOTHER'S MAIDEN NAME Unk	14. NAME OF HUSBAND OR WIFE Kathryn Nerka
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY NO. 499-20-4195	17. INFORMANT Address Kathryn Nerka St. Joseph, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH sudden unknown 4200
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Enroute to work	20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Joseph, Mo.	
21. I attended the deceased from 9-17-56 to 11-19-57 and last saw ^{him} alive on 10-28-57 Death occurred at 7:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Martin H Christ MD		22b. ADDRESS 6106 King Hill Ave.	22c. DATE SIGNED 11-22-57
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 11/21/57	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county), (State) St. Joseph, Mo
24. FUNERAL DIRECTOR	ADDRESS St. Joseph, Mo	25. DATE RECD. BY LOCAL REG. Nov. 27, 1957	26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

48

3101

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DEC 5 1951

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, ~~and~~, Student Embalmer No. working under my personal supervision.

Student

Signature of Student Embalmer

Signed *Joseph Papp*

Licensed Embalmer No. *3986*

P. O. Address *Joseph Papp*

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.