

FILED JAN 17 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE OF MISSOURI 3382

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 183

300
-57

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, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 LITTLE SISTERS OF THE POOR		Length of stay in 1b	STREET ADDRESS (If outside, give location) 16 3400 So GRAND		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle Last NICHOLS			4. DATE OF DEATH Month JAN Day 5 Year 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 27 1878	9. AGE (In years last birthday) 79	IF FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) GERMANY	12. CITIZEN OF WHAT COUNTRY? U-S-A	
13a. FATHER'S NAME VALENTINE MICKA		13b. MOTHER'S MAIDEN NAME CATHERINE PORT		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) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT THOMAS BRINKER 9938 TIMOTHY LANE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Heart Disease DUE TO (b) Sen arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0					INTERVAL BETWEEN ONSET AND DEATH Yes Yes
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 Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <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 St. Louis, Mo		COUNTY STATE
21. I attended the deceased from Death occurred at Sept. 1957 to 2:30 P. m on the date stated above; and to the best of my knowledge, from the causes stated. and last saw her alive on 1/3/58					
22a. SIGNATURE Emergia Ind			22b. ADDRESS 8059 Watson Rd		22c. DATE SIGNED 1/7/58
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
BURIAL		JAN 8 1958	ST PETER + PAUL CEM		ST. LOUIS MO
24. FUNERAL DIRECTOR Thomas Rutis 2906 Gravoie			25. DATE RECD. BY LOCAL REG. JAN 8 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith MO mjb	

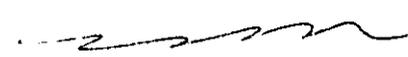
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

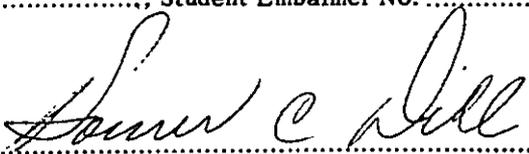
MEDICAL CERTIFICATION

W01-8206
E-5th Tr. Assn. Sec'y

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 
Licensed Embalmer No. 4347

P. O. Address 2906 Staver

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.