

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038073  
STATE FILE NUMBER  
10299  
Registrar's No.

FILED NOV 10 1958 Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Charles</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Charles</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
e. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospt.</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>2509 Elm St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Sophie W. Nolle</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>24</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1903</b>	9. AGE (In years last birthday) <b>55</b> IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	11. BIRTHPLACE (City and state or country) <b>St. Charles County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Fredrick Nolle</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Hagameier</b>		14. NAME OF HUSBAND OR WIFE <b>Hugo Nolle</b>	
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. <b>486-40-4219</b>		17. INFORMANT <b>Hugo Nolle, St. Charles, Mo.</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c); PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>				5 yrs	
DUE TO (c) <b>332x</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <b>9/17/58</b> and last saw her alive on <b>10/24/58</b> Death occurred at <b>4:45 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Frede Mortensen M.D.</b>			22b. ADDRESS <b>3701 Grandel Square</b>		22c. DATE SIGNED <b>10/27/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 28, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Charles, Missouri</b>
24. FUNERAL DIRECTOR <b>Arthur C. Baue, St. Charles, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>OCT 27 '58</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *David C. Wace* .....

Licensed Embalmer No. *5060* .....

P. O. Address *St. Charles* .....

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.