

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011250
STATE FILE NUMBER
2029

FILED MAR 17 1959 Registration District No. Primary Registration District No. Registrar No. 2029

S. 300
v. 1-57
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0193

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda Hosp.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>3809 DOVER</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Nuebling</u> Last			4. DATE OF DEATH Month <u>Feb.</u> Day <u>23</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 11, 1864</u>	9. AGE (In years last birthday) <u>94</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u> IF UNDER 24 HRS. Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ferdinand Nuebling</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Gutjahn</u>		14. NAME OF HUSBAND OR WIFE <u>Albertine (Deceased)</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 Address <u>Elizabeth Bartosch 3809 Dover</u>		
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>& decompensation</u> <u>arteriosclerosis, general</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>420.0</u>					INTERVAL BETWEEN ONSET AND DEATH
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 <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>May 1946</u> to <u>Feb 23, 1959</u> and last saw her alive on <u>Feb 23, 1959</u> Death occurred at <u>11:20 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Joseph E. Carney M.D.</u>			22b. ADDRESS <u>906 Olive</u>		22c. DATE SIGNED <u>2-24-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Feb. 26, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Mausoleum</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, County, Mo.</u>
24. FUNERAL DIRECTOR <u>Schumacher's 3013 Meramec St.</u>			25. DATE RECD. BY LOCAL REG. <u>FEB 26 '59</u>	26. REGISTRAR'S SIGNATURE <u>Lois Smith, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

11. 9. 13

DR. 906 CLINT
FRISCO
DR. CHANEY

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 *Jack Haupt*

Licensed Embalmer No. *4746*

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.