THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 59-011874

FILED MAR 30 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 765

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Normandy — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 4 Charles 1st Nursing Home — Length of stay in Ib 4 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY St. Louis
c. CITY OR TOWN Overland City 423 X 6 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) #41 W. Sherwood Drive — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First Frederick Middle J Last Nollmann

4. DATE OF DEATH Month March Day 19 Year 1959

5. SEX male 0

6. COLOR OR RACE white

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]

8. DATE OF BIRTH December 28, 1871

9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Polisher (Retired)

10b. KIND OF BUSINESS OR INDUSTRY Landis Machine Co

11. BIRTHPLACE (City and state or country) St. Charles, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Frederick Nollmann

13b. MOTHER'S MAIDEN NAME Betty Linnemann

14. NAME OF HUSBAND OR WIFE deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 488-12-9532

17. INFORMANT Address Mrs. Arthur Glusenkamp, #41 W. Sherwood Dr

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Carcinoma of Stomach — 1 yr.
DUE TO (c) 151X
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 [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

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 [ ] NOT WHILE AT WORK [ ]

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 1-10-58, to 3/19/59 and last saw her/him alive on 3/19/59
Death occurred at 5:00 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Burton A. Shotz (Degree or title) M.D.

22b. ADDRESS 4652 MARYLAND

22c. DATE SIGNED 3/20/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE March 21, 1959

23c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc., 2161 E. Fair

25. DATE RECD. BY LOCAL REG. 3-20-59

26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.