

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023743

STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1578

| | | | | | |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY St. Louis, Mo. | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Koch | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Jennings | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Robert Koch Hosp. | | Length of stay in lb 20 month | d. STREET ADDRESS (If outside, give location) 7429 Chandler | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First CHARLES , Middle CHARLES , Last NOLTE | | | 4. DATE OF DEATH Month June Day 7 Year 1959 | | |
| 5. SEX Male | 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 July 26, 1879 | 9. AGE (In years) 79 | IF UNDER 1 YEAR Months 2 Days 2 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | 11. BIRTHPLACE (City and state or country) Germany | | 12. CITIZEN OF WHAT COUNTRY? US |
| 13a. FATHER'S NAME Wm. Nolte | | 13b. MOTHER'S MAIDEN NAME Not Known | | 14. NAME OF HUSBAND OR WIFE Anna Nolte | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes Spanish American | | 16. SOCIAL SECURITY NO. 489 22 4361 | 17. INFORMANT Address Louise Frankenberg 7429 Chandler | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepato-cellular Jaundice | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Acute Liver Failure | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acute Gastro-intestinal Bleeding and Shock | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 12:25 Month, Day, Year 6-7-59 | | | | | |
| 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 5-25-59 to 6-7-59 and last saw her alive on 6-6-59 Death occurred at 6-7-59 12:25 PM on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Leon H. Studer MD | | 22b. ADDRESS Robert Koch Hosp. | | 22c. DATE SIGNED 6-7-59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 6/10/59 | 23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis County Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Buchholz Mortuary 5967 W. Florissant | | | 25. DATE RECD. BY LOCAL REG. 6-10-59 | | REGISTRAR'S SIGNATURE John C. Murphy MD |

(Licensed Embalmer's Statement on Reverse Side)

health, welfare, public service
 100
 157
 40
 MEDICAL CERTIFICATION
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Social, coroner, etc. - must be causally related.
 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 *Wilfred B. Beckler*

Licensed Embalmer No. *4551*
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.