

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027726

FILED VS AUG 7 1959

Registration District No. _____ Primary Registration District No. 500 Registrar's No. 2023 STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Koch, Missouri</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____ | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | Length of stay in 1b <u>2171</u> days | c. CITY OR TOWN <u>St. Louis</u> | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Robt. Koch Hospital</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>118 N. Broadway</u> |
| | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle _____ Last <u>Nibberich</u> | 4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1959</u> |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-16-91</u> | 9. AGE (last birthday) <u>68</u> Yrs. | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nil</u> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Bernard Nibberich</u> | 13b. MOTHER'S MAIDEN NAME <u>Margaret Singer</u> | 14. NAME OF HUSBAND OR WIFE _____ |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W.W.I</u> | 16. SOCIAL SECURITY NO. <u>500-07-0089</u> | 17. INFORMANT <u>Lawrence Nibberich</u> Address <u>5923 Floy</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2171</u> days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>002X</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) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

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| 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.) |
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| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | 20d. INJURY OCCURRED WHILE AT WORK <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 _____ |
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| 21. I attended the deceased from <u>8-18-53</u> to <u>7-29-59</u> and last saw her/him alive on <u>7-29-59</u> Death occurred at <u>8:30</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <u>Bernard Friedman M.D.</u> (Degree or title) | 22b. ADDRESS <u>Robert Koch Hospital</u> | 22c. DATE SIGNED <u>7-29-59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 23b. DATE <u>7/31/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Buchholz Mort. 5967 W. Florissant Av.</u> ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>7-30-59</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u> |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Walter M. Beal

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 conform 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.