

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

XC-2060852 SL1249 FILED VS OCT 8 1959

59-034132

2 8877

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY MACOUPIN		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND, ST LOUIS, MO.		Length of stay in 1b 4 DAYS	c. CITY OR TOWN WILSONVILLE		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDWARD Middle A. Last NADLER			4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1959		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-5-96	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER		10b. KIND OF BUSINESS OR INDUSTRY MINING	11. BIRTHPLACE (City and state or country) WENONA, ILLINOIS		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME ALOIS NADLER		13b. MOTHER'S MAIDEN NAME HELEN OSWALD		14. NAME OF HUSBAND OR WIFE ROSE NADLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO. 342-10-8024		17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE LUNG					INTERVAL BETWEEN ONSET AND DEATH 4 YEARS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					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
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 165x					
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 _____ 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
21. <input checked="" type="checkbox"/> attended the deceased from 9-21-59 to 9-25-59 and last saw him alive on 9-25-59 Death occurred at 7:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Do not sign in title) ROLAND B. HERNITZ, M.D.			22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 9-25-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/26/59	23c. NAME OF CEMETERY OR CREMATORY Gillespie, Illinois.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.,			25. DATE RECD. BY LOCAL REG. SEP 26 '59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Harvey Kable

Licensed Embalmer No. 4576

P. O. Address St Louis, Mo

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.