

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038432

FILED VS NOV 16 1959

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 2977 STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>St. Louis</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Valley Park</u>		a. STATE <u>Mo.</u>		b. COUNTY <u>St. Louis</u>	
Length of stay in 1b <u>6 Mo.</u>		c. CITY OR TOWN <u>Sappington 23</u>		d. STREET ADDRESS (If outside, give location) <u>117 Blackthorn Dr.</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>Moll Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE MAY NITSCHKE</u>				4. DATE OF DEATH Month Day Year <u>Nov, 7, 1959.</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>9-24-1885</u>	9. AGE (last birthday) <u>74</u>	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) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (City and state or country) <u>Cadet Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Harry Purington</u>			13b. MOTHER'S MAIDEN NAME <u>Osceda Thompson</u>		14. NAME OF HUSBAND OR WIFE <u>Frederick C Nitsche</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>Mrs. F.G. Meyers 117 Blackthorn Dr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cerebral accident - Subarachnoid hemorrhage July 1959</u>							
DUE TO (b) <u>General arteriosclerosis - cerebral arteriosclerosis</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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 checked="" 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>1920</u> to <u>11-7-59</u> and last saw her/him alive on <u>11-3-59</u> . Death occurred at <u>4:30</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>D. Thompson M.D.</u>				22b. ADDRESS <u>634 W. Grand Blvd. St. Louis</u>		22c. DATE SIGNED <u>11-8-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-10-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Highland Lawn Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Terre Haute Ind. Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Parker-Aldrich Webster Groves Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>11-9-59</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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 _____

Leslie Halch

Licensed Embalmer No. 4395

P. O. Address Adopter Gro

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.