

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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FILED VS JAN - 8 1960

211596

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b -----		c. CITY OR TOWN St. Louis, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1506 Montgomery St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First MICHAEL Middle Last NESTMANN				4. DATE OF DEATH Month December Day 12, Year 1959									
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-15-85		9. AGE (last birthday) 74 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) formerly: Metal plater				10b. KIND OF BUSINESS OR INDUSTRY Metal Plating		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Henry Nestmann				13b. MOTHER'S MAIDEN NAME Mary (Lohe)				14. NAME OF HUSBAND OR WIFE ---					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. None		17. INFORMANT Unknown		Address Mrs. Marie Back, 5609 Hodiamont Avenue						
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) Lobar pneumonia, left lung (pneumococcus)													
With multiple abscesses													
DUE TO (b) Pulmonary tuberculosis													
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.													
DUE TO (c) Generalized arteriosclerosis													
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. 002x <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. I attended the deceased from Nov. 10, 1947 to Dec. 12, 1959 and last saw ^{her} him alive on Dec. 12, 1959 Death occurred at 4:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. Dr. Joseph Cagliariardo													
22a. SIGNATURE <i>Dr. Joseph Cagliariardo</i> (Degree or title)						22b. ADDRESS 5400 Arsenal St.			22c. DATE SIGNED 12-14-59				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-16-59		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION (City, town, or county) St. Louis, Missouri		(State)				
24. FUNERAL DIRECTOR CALVIN F. FEUTZ FUNERAL HOME, St. Louis, 15, Missouri				ADDRESS 4828 Natural Bridge Blvd.,		25. DATE RECD. BY LOCAL REG. DEC 14 1959		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>					

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 Ralph C. Zindler

Licensed Embalmer No. 4275

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.