

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 23 1959

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211532

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 Mo b. COUNTY	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		d. STREET ADDRESS (If outside, give location) 1206 SIDNEY	

3. NAME OF DECEASED (Type or print) First **NICHOLAUS** Middle **STAUDT** Last _____

4. DATE OF DEATH Month **DEC, 9,** Day **1959** Year _____

5. SEX male	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH DEC. 9 1896	9. AGE (last birthday) 73	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) RETIRED BARBER	10b. KIND OF BUSINESS OR INDUSTRY FAMOUS-BARRCO	11. BIRTHPLACE (City and state or country) AUSTRIA	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME **Peter STAUDT** 13b. MOTHER'S MAIDEN NAME **UNKNOWN** 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. **498-16-1088** 17. INFORMANT Address **ANNA COLT 1206 SIDNEY**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Sq. Cell Ca Tongue**

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____

DUE TO (c) **1419**

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour _____ Month, Day, Year _____

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **12/ 4/59** to **12/ 9/59** and last saw her/him alive on **12/9/59**

Death occurred at **8:10p** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Boyd Smith, M.D.** 22b. ADDRESS **1515 LAFAYETTE AVE** 22c. DATE SIGNED **12/10/59**

23a. BURIAL, CREMATION, OR REMOVAL (Specify) **BURIAL** 23b. DATE **DEC. 14 1959** 23c. NAME OF CEMETERY OR CREMATORY **S-S. PETER + PAUL** 23d. LOCATION (City, town, or county) (State) **ST. LOUIS Mo.**

24. FUNERAL DIRECTOR ADDRESS **Thomas Lutie 2906 Gravois** 25. DATE RECD. BY LOCAL REG. **DEC. 12 1959** 26. REGISTRAR'S SIGNATURE **Boyd 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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Grav

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.