

**MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS FEB 25 1960**

**2 1074**

STATE FILE NUMBER

**60-008684**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived, City, institution, Residence before admission)		
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS Mo</b>			c. CITY OR TOWN <b>AFFTON</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHN'S Hosp.</b>			d. STREET ADDRESS (If outside, give location) <b>7231 CHESHIRE LANE</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>NILICA</b> Last			4. DATE OF DEATH <b>JAN. 27 1960</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 13 1911</b>	9. AGE (last birthday) <b>49</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OFFICE MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INT. LIGHT MFG. Co</b>		11. BIRTHPLACE (City and state or country) <b>Mo</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. NAME OF HUSBAND OR WIFE <b>FRANK N. NILICA</b>			
13a. FATHER'S NAME <b>KARAL SCHUETTLER</b>		13b. MOTHER'S MAIDEN NAME <b>KATHERINE MARBEK</b>		14. NAME OF HUSBAND OR WIFE <b>FRANK N. NILICA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>488-03-4237</b>		17. INFORMANT Address <b>FRANK N. NILICA AFFTON Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <b>Rheumatic Heart Disease</b>					<b>unknown</b>
DUE TO (c) <b>416X</b>					
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 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 Month, Day, Year a.m. p.m.					
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 <b>15 April 58</b> to <b>27 Jan 60</b> and last saw her <sup>him</sup> alive on <b>27 Jan 60</b> Death occurred at <b>6:00 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>John M. Clam M.D.</b>			22b. ADDRESS <b>4401 Hampton</b>		22c. DATE SIGNED <b>29 Jan 60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
<b>BURIAL</b>		<b>JAN. 30 1960</b>		<b>S.S. Peter + Paul Cem.</b>	
23d. LOCATION (City, town, or county) (State)		23e. REGISTERAR'S SIGNATURE			
<b>ST. LOUIS Mo</b>		<b>Carl Smith, M.D.</b>			
24. FUNERAL DIRECTOR ADDRESS			25. DATE RECD. BY LOCAL REG.		26. REGISTERAR'S SIGNATURE
<b>Thomas Lutts 2906 Gravis</b>			<b>JAN 30 1960</b>		<b>Carl Smith, M.D.</b>

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 \_\_\_\_\_

Licensed Embalmer No. 4347

P. O. Address 2906 Doo

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.