

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. MAY 25 1960

4826-60-021343

INDEXED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____ STATE FILE NUMBER

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|---------------------------|---------------------|
| 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 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 3900a N.22nd Str. | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First MINNIE Middle J Last NOLTE | | | | 4. DATE OF DEATH Month May Day 6 Year 1960 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 15, 1874 | 9. AGE (last birthday) 85 | 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) None | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | |
| 13a. FATHER'S NAME James W Johnson | | | 13b. MOTHER'S MAIDEN NAME Fibbie Butler | | | 14. NAME OF HUSBAND OR WIFE (Late) William L Nolte | | | |
| 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. | | 17. INFORMANT Address Jeanette L Miller daughter 2029a Obear | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intertrochanteric fracture of left femur. DUE TO (b) Generalized arteriosclerosis DUE TO (c) 904.0 21 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 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 type="checkbox"/> No <input checked="" type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter place of injury in PART I or PART II of item 18.) Slipped in fall at home collar about April 20 1960 | | | | | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. 4 2060 | 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.) 20 Home | | 20f. CITY, TOWN, OR LOCATION St Louis Mo. | | | | COUNTY St Louis | STATE Mo. |
| 21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Joseph J. Quinn | | | | 22b. ADDRESS 1300 Clark | | | 22c. DATE SIGNED 5-7-60 | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Removal | | 23b. DATE May 9 1960 | 23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens | | 23d. LOCATION (City, town, or county) (State) St. Louis County Mo. | | | | |
| 24. FUNERAL DIRECTOR Henry Leidner Undertaking Co 2223 St. Louis Ave. | | | | 25. DATE RECD. BY LOCAL REG. MAY 7 1960 | | 26. REGISTRAR'S SIGNATURE Loal 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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Alfred Mayfield

Licensed Embalmer No. 3011

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.