

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

**-61-019868**  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1281

AMENDED

FILED MAY 22 1961

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Winchester</b>	Length of stay in 1b <b>8 days</b>	c. CITY OR TOWN <b>Chesterfield</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Manchester Nursing H.</b>		d. STREET ADDRESS (If outside, give location) <b>Olive St. Rd.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Otto</b> Middle <b>Nelke</b> Last <b>Nelke</b>	4. DATE OF DEATH Month <b>5</b> Day <b>4</b> Year <b>1961</b>
--	--

5. SEX <b>male</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>3-13-81</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>4</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
-----------------------	----------------------------------	---	------------------------------------	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis Co., Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	---	--	--

13a. FATHER'S NAME <b>Andrae Nelke</b>	13b. MOTHER'S MAIDEN NAME <b>Gorselia Hardwick</b>	14. NAME OF HUSBAND OR WIFE <b>Annie Nelke</b>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT Address <b>Annie Nelke Chesterfield, 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>CARDIO VASCULAR DISEASE</b> DUE TO (b) <b>SENILITY</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <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 type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>BALLWIN</b>	COUNTY <b>Mo.</b>	STATE
---	--	--	--	----------------------	-------

21. I attended the deceased from **APRIL 26, 1961** to **MAY 4, 1961** and last saw <sup>her</sup>him alive on **MAY 4, 1961**  
Death occurred at **5:30 P. m** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>B. R. Loving, M. D.</b>	(Degree or title)	22b. ADDRESS <b>BALLWIN, Mo.</b>	22c. DATE SIGNED <b>5-5-61</b>
--	-------------------	-------------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5-8-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>	23d. LOCATION (City, town, or county) <b>Manchester, Mo.</b>	(State)
--	----------------------------	--	---	---------

24. FUNERAL DIRECTOR <b>Schrader Funeral Home Ballwin, Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>5-5-61</b>	REGISTRAR'S SIGNATURE <i>[Signature]</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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Richard M. Bopp

Licensed Embalmer No. 4584

P. O. Address Bellwin, Va

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.