

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045943

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 313

FILED JAN 5 1962

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Charles</u>		Length of stay in lb <u>D. O. A.</u>	c. CITY OR TOWN <u>St. Charles</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1132 Harvester Rd.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Emil</u> Middle <u>C.</u> Last <u>Nowack</u>	4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1961</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/1911</u>	9. AGE (last birthday) <u>50</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>6</u>	IF UNDER 24 HR. Hours <u>—</u> Min. <u>—</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Auto-Garage</u>	11. BIRTHPLACE (City and state or country) <u>Clayton, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Albert Nowack</u>	13b. MOTHER'S MAIDEN NAME <u>Ida Quade</u>	14. NAME OF HUSBAND OR WIFE <u>Erma Bock Nowack</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes World War II</u>	17. INFORMANT Address <u>Mrs. Erma Nowack, St. Charles, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>Instantaneous</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio-sclerotic Cardiovascular Disease</u>		
DUE TO (c) <u>—</u>		
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 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.) <u>—</u>
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20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	Month, Day, Year <u>—</u> <u>—</u> <u>—</u>
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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.) <u>—</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>—</u> <u>—</u> <u>—</u>
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21. I attended the deceased from 1949 to December 20, 1961 and last saw him alive on December 9, 1961
Death occurred at: 8:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Don L. Randall, M.D.</u>	22b. ADDRESS <u>220 S. 6th St. Charles, Mo.</u>	22c. DATE SIGNED <u>Dec. 21, 1961</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec. 23, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Charles, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Arthur C. Baue, St. Charles, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Dec. 21-61</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

MAR 15 1962

VS MAR 15 1962

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

John C. Smith

Licensed Embalmer No. 5145

P. O. Address St. Charles,

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.