

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044690  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10930**

**FILED NOV 19 1962**

VS 300  
Rev. 4/59.

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		c. CITY OR TOWN <b>University City</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>BARNES HOSPITAL</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>6643 Kingsbury Ave</b>				Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>KATE</b> Middle <b>L.</b> Last <b>NYVALL</b>			4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>13</b> Year <b>1962</b>			5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2/14/1899</b>		9. AGE (last birthday) <b>63</b>		IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>				11. BIRTHPLACE (City and state or country) <b>Denver, Colorado</b>				12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Wm. LaCoste</b>				13b. MOTHER'S MAIDEN NAME <b>Jane Jennings</b>				14. NAME OF HUSBAND OR WIFE <b>Martin Nyvall, late</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of serv)				16. SOCIAL SECURITY NO. <b>5</b>				17. INFORMANT <b>Martin W. Nyvall, 305 Pam St St. Charles, MO.</b>				Address					
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA WITH ATELECTASIS</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <b>RHEUMATOID ARTHRITIS AND DIABETES MELLITUS</b>		YEARS					
										DUE TO (c) <b>722.0</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 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 <b></b> a.m. <b></b> p.m. <b></b>		Month, Day, Year <b></b>															
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>DEC. 28, 1956</b> to <b>NOV. 13, 1962</b> and last saw her alive on <b>NOV. 13, 1962</b>				Death occurred at <b>6:40 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>E. P. Demilia, M.D.</i> (Degree or title) <b>M. D.</b>				22b. ADDRESS <b>BARNES HOSPITAL</b>				22c. DATE SIGNED <b>11/13/62</b> (State)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>11/14/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wasatch Lawn Cemetery</b>		23d. LOCATION (City, town, or county) <b>Salt Lake City, Utah</b>											
24. FUNERAL DIRECTOR <b>Lupton Chapel, inc 7233 Delmar Blvd</b> ADDRESS				25. DATE REGD. BY LOCAL REG. <b>NOV 13 1962</b>		26. REGISTRAR'S SIGNATURE <i>Boal Smith, M.D.</i>											

**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 \_\_\_\_\_

*Arnold M. Schoene*

Licensed Embalmer No. \_\_\_\_\_

*3864*

P. O. Address \_\_\_\_\_

*Schoene, M*

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.