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 5-17-39  
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DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

4645

FILED MAR 9 1945

318

Registration District No.

1003

State File No.

Registrar's No.

1668

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town St. Louis  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Lutheran Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

2. USUAL RESIDENCE OF DECEASED: 000  
 (a) State Missouri (b) County 17  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL") 9 25  
 (d) Street No. 1609 Market St.  
 (If rural, give location)  
 (e) Citizen of foreign country? 0 (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Nick Nicolaides  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Feb. day 17  
 year 1945 hour 7 minute 05 P.M.  
 21. I hereby certify that I attended the deceased from Feb 14  
1945 to Feb 17 1945;  
 that I last saw h. alive on Feb 17 1945  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: ? (Month) (Day) (Year)

Immediate cause of death: Ch. Nephritis  
Ch. Myocarditis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions: Syphilis  
 (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
abt -60 ? \_\_\_\_\_ hr. \_\_\_\_\_ min.

PHYSICIAN  
 Underline the cause to which death should be charged statistically.  
 \_\_\_\_\_

9. Birthplace: Albania (State or foreign country)  
 10. Usual occupation: Cook  
 11. Industry or business: Retired

MOTHER FATHER {  
 12. Name Don't Know  
 13. Birthplace Don't Know (City, town, or county) (State or foreign country) 9  
 14. Maiden name Don't Know  
 15. Birthplace Don't Know (City, town, or county) (State or foreign country) 9

16. (a) Informant: Nick P. Derris  
 (b) Address: 2625a Nebraska Ave.  
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Feb. 20, 1945  
 (Month) (Day) (Year)  
 (c) Place: Burial or cremation: St. Matthews Cemetery

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
 \_\_\_\_\_

18. (a) Signature of funeral director: Weick Bros.  
 (b) Address: 2201 S. Grady Bl.  
 19. (a) EFP 20 1945 (Date received local registrar) (b) J. F. Bredesch (Registrar's signature)

While at work? R. Berg (Specify type of place) (c) Means of injury: \_\_\_\_\_  
 23. Signature: R. Berg (M. D. or other) \_\_\_\_\_  
 Address: 2201 S. Grady Bl. Date signed: 2/19/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

0  
 7  
 9

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Dwight A. Stewart*

Licensed Embalmer No..... 3722

P. O. Address..... 412 Duchouquette St.

**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 this body is not embalmed, fact should be so stated above.**