

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35178

State File No. _____

Registration District No. **DEC 31 1945**

Primary Registration District No. **1003**

Registrar's No. **10415**

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Nicholas Delorme APLE
3. (b) If veteran, name war No
3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 7 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 7 22 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Upholsterer

11. Industry or business _____

MOTHER FATHER

12. Name Nicholas Delorme
13. Birthplace Canokia Illinois
(City, town, or county) (State or foreign country)
14. Maiden name Anna Lava
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Otto Delorme
(b) Address 2826 Clifton Ave.

17. (a) Burial (b) Date thereof 12-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) NOV 30 1945 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3 N. 9th St.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29th
year 1945 hour 12:45 minute A M.
21. I hereby certify that I attended the deceased from 11/18/45
_____, 19____, to 11/29/45, 19____;
that I last saw him alive on 11/29/45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Carcinoma of NECK,
T. thyroid gland origin
Due to _____
Due to _____
Other conditions _____
(Includes pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: _____
Of operations 0
Of autopsy None

Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature 1515 Lafayette 11/29/45 (M, D, or other)
Address 2900 ... Date signed _____

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.....

John Agnoskie

.....
Licensed Embalmer No. *3398*

P. O. Address.....

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.