

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28528**
Registrar's No. **7124**

FILED AUG 25 1951

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis, City Hosp. #1		f. STREET ADDRESS (If rural, give location) 3224 MONTGOMERY ST	
3. NAME OF DECEASED (Type or Print) a. (First) Nicholas b. (Middle) c. (Last) Mertz		4. DATE OF DEATH (Month) (Day) (Year) Aug. 6, 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH AUG. 28-1878
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPING CLERK	11. BIRTHPLACE (State or foreign country) CHICAGO ILL
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPING CLERK		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME MATHIS		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE MAY STEWART
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mr. Repede 2331 Maullonphy
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Metastasis to lumbar vertebrae DUE TO (c) Decubitus ulcers II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart failure	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 177X	
22. I hereby certify that I attended the deceased from May 4, 1951 to Aug. 6, 1951 , that I last saw the deceased alive on Aug. 6, 1951 and that death occurred at 7:25 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Chapman R. Brooks, M.D.		23b. ADDRESS 1515 1/2 Lafayette	23c. DATE SIGNED 8/7/51
24a. BURIAL CREMATION REMOVAL (Specify) BURIAL	24b. DATE AUG 11-51	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST LOUIS MO
DATE REC'D BY LOCAL REG. AUG 10 1951	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Paulley Kelly 4386 Junelle	

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 _____

Students of Mortuary College
working under my personal supervision.

Student Embalmer No.

Signed

James A. Lammers

Signed.....
Student Embalmer

Licensed Embalmer No. *4142*

P. O. Address *St Louis*

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.