

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31734

State File No.

8200

Registrar's No.

FILED SEP 22 1951

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

BIRTH NO.

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis, Missouri</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> <u>2129</u>	
c. LENGTH OF STAY (In this place) <u>12</u>		d. STREET ADDRESS (If rural, give location) <u>245 Union Avenue</u> <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Gatesworth Hotel</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Edith</u>	b. (Middle) <u>Fleming</u>	c. (Last) <u>Nickerson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 15 1951</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec. 17, 1869</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	11. BIRTHPLACE (State or foreign country) <u>Dundas, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Fleming</u>	13b. MOTHER'S MAIDEN NAME <u>Kate McWilliams</u>	14. NAME OF HUSBAND OR WIFE <u>Robert Alden Nickerson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Edith N. Caskie</u>	ADDRESS <u>6912 Amherst Ave.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>9 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart disease</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic intestinal hepatitis</u> DUE TO (c) <u>Senile changes</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>no</u>	19b. MAJOR FINDINGS OF OPERATION <u>no</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>5 9 24</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>5 9 24</u>
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22. I hereby certify that I attended the deceased from Feb 15, 1940, to Sept. 15, 1951, that I last saw the deceased alive on Dec. 19, 1951, and that death occurred at 8:00 m., from the causes and on the date stated above.

23a. SIGNATURE <u>Joseph Davis</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>406 Winice Bldg</u>	23c. DATE SIGNED <u>9-16-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	24b. DATE <u>Sept. 17, '51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Olney, Illinois</u>
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DATE REC'D BY LOCAL REG. <u>SEP 17 1951</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>C. R. Lupton & Sons</u>	ADDRESS <u>7233 Delmar Blvd.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

FEB 19 1954

APR 17 1957

1957 FEB 19 1954

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
Student Embalmer

Signed *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address *St. Louis, Mo.*

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.