

FILED JAN 26 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3160
Registrar's No. 0379

318

1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS MO</u>			c. LENGTH OF STAY (In this place) <u>3 DAYS</u>		1. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ALEXIAN BROS. Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>5532 GRANT PL.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES J.</u>			b. (Middle)		c. (Last) <u>NIES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 13 1952</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>JUNE 2 1870</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SHEET METAL WORKER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZENRY OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOHN NIES</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>LOUISE NIES</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>LOUISE NIES 5532 GRANT PL.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Shuntum taken both by line & operation</u>				DUE TO (b) _____			<u>2 months</u>
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death) <u>Diagnosis: Vascular Renal Disease Death Myocardial Degeneration</u>			<u>7 years</u>
19a. DATE OF OPERATION <u>Jan. 12 1952</u>		19b. MAJOR FINDINGS OF OPERATION <u>Complete System Obstruction Large by line & shunt</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>5400</u>			
22. I hereby certify that I attended the deceased from <u>Nov-5, 1951</u> , to <u>Jan-13, 1952</u> , that I last saw the deceased alive on <u>Jan-13, 1952</u> , and that death occurred at <u>10:00 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. Wm. C. Wayland M.D.</u>			23b. ADDRESS <u>3201 - 50th St. St. Louis, Mo</u>			23c. DATE SIGNED <u>1-14-52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JAN. 16 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>S.S. PETER & PAUL</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>JAN 14 1952</u>		REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Rutis 2906 Morris</u>			

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

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 _____

Licensed Embalmer No. 4347

P. O. Address 2906 Hawaii

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.