

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**10310**

State File No. \_\_\_\_\_  
Registrar's No. **2348**

FILED **MAR 19 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

|   |  |  |  |
|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY _____   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY _____ |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> |  | c. CITY OR TOWN <u>St. Louis</u>   |  |
| c. LENGTH OF STAY (in this place) <u>3</u>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>        |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Clark Lane Memorial Hosp.</u>                      |  | e. STREET ADDRESS (If rural, give location) <u>3719 Kaelen</u>   |  |

|   |                                  |   |  |
|---|----------------------------------|---|--|
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <u>HENRY PETER NIKOLAISEN</u> |                                  | <b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MAR. 12, 1954</u>                                   |  |
| a. (First)  |                                  | b. (Middle)   |  |
| c. (Last)   |                                  |   |  |
| <b>5. SEX</b> <u>M</u>  | <b>6. COLOR OR RACE</b> <u>W</u> | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Married</u>                        | <b>8. DATE OF BIRTH</b> <u>July 21, 1895</u>                 |
| <b>9. AGE</b> (In years) <u>58</u>  |                                  | <b>10a. USUAL OCCUPATION</b> (Give kind of work or giving most of time if retired) <u>Meat Cuts</u> | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Meat Packing</u> |
| <b>11. BIRTH PLACE</b> (City and State or Foreign Country) <u>Russia</u>    |                                  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Russia</u>   |  |

|  |   |  |
|--|---|--|
| <b>13a. FATHER'S NAME</b> <u>Unknown</u>   | <b>13b. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>   | <b>14. NAME OF HUSBAND OR WIFE</b> <u>Julia Nikolaisen</u>           |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> | <b>16. SOCIAL SECURITY NO.</b> (If you give war or dates of service) <u>488-10-8442</u> | <b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Peter Jay Nikolaisen</u> |
|  |   | <b>18. ADDRESS</b> <u>4309 Wab</u>                                   |

|  |   |  |   |
|--|---|--|---|
| <b>18. CAUSE OF DEATH</b><br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | <b>1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Congestive Heart Failure</u>   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> |
|  | <b>ANTECEDENT CAUSES</b><br>DUE TO (b) <u>Hypertension</u><br><i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> |  |   |
|  | <b>II. OTHER SIGNIFICANT CONDITIONS</b><br><i>Conditions contributing to the death but not related to the disease or condition causing death.</i>                     |  |   |

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|---|--|--|
| <b>19a. DATE OF OPERATION</b>                                 | <b>19b. MAJOR FINDINGS OF OPERATION</b>  | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)               | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | <b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>                                     |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) | <b>21e. INJURY OCCURRED</b><br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | <b>21f. HOW DID INJURY OCCUR?</b> <u>442x</u>  |

**22. I hereby certify that I attended the deceased from** Mar. 10, 1954, to Mar. 12, 1954, that I last saw the deceased alive on Mar. 12, 1954, and that death occurred at 1:15 P. m., from the causes and on the date stated above.

|  |  |  |
|--|--|--|
| <b>23a. SIGNATURE</b> _____ (Degree or title)                          | <b>23b. ADDRESS</b> <u>Clark Lane Hospital</u>     | <b>23c. DATE SIGNED</b> <u>3-13-54</u>                         |
| <b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>        | <b>24b. DATE</b> <u>3/15/54</u>                    | <b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>7th Hope Cem.</u> |
| <b>24d. LOCATION</b> (City, town, or county) (State) <u>Jersey MO.</u> | <b>DATE REC'D BY LOCAL REG.</b> <u>MAR 15 1954</u> | <b>REGISTRAR'S SIGNATURE</b> <u>Carl Smith</u>                 |
| <b>FUNERAL DIRECTOR'S SIGNATURE</b> <u>Carl Smith</u>                  | <b>ADDRESS</b> <u>7420 Michigan</u>                |  |

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

No. 300  
10-48

*Dr Frank Smith - Park Lane Hosp.*

**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.....  
Signature of Student Embalmer

Signed *W. G. Peterson*.....

Licensed Embalmer No. *376*.....

P. O. Address *7/20 N. Michigan*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.