

FILED JUN 7 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18394

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5137**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis, 20<sup>th</sup></b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1.</b>		Length of stay in lb <b>3 Days</b>	d. STREET ADDRESS <b>4122 N. Kingshighway</b>		(If outside, give location) Reside on Farm No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>VERNA Lee NICOLAS</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>25</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Separated</b>	8. DATE OF BIRTH <b>Dec. 30, 1918</b>	9. AGE (In years last birthday) <b>37</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Beach Grove, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Rosenberg</b>			14. MOTHER'S MAIDEN NAME <b>Florence Dodson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No. Nil</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Flore Dodson, 4122 N. Kingshighway</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute gastric necrosis with perforation of unknown etiology.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>Gangrene of ileum, of unknown etiology</b>					<b>6 days.</b>
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (I) <b>Renal shutdown - ?recurrently recurrent</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>578X</b>			
20c. TIME OF INJURY Hour a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>575X</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>5/22/56</b> to <b>5/25/56</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>5/25/56</b> Death occurred at <b>8:58 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>William N. Blalock M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>5/28/56.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5-29-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, County Mo.</b>
24. FUNERAL DIRECTOR <b>Kosakowski &amp; Sons</b>		ADDRESS <b>2205 St. Louis,</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 28 1956</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>

(Licensed Embalmer's Statement on Reverse Side)

m JB.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH

2291 25 YA

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, or by ..... Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *J W Binkley* .....  
Licensed Embalmer No. *3*

P. O. Address *116* .....

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.