

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29267

FILED AUG 24 1956

318

1003

STATE FILE NUMBER

6720

Registration District No. Primary Registration District No. Registrar's No.

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, give TOWNSHIP only) OR KOKK St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR KOKK St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb		d. STREET (If outside, give location) ADDRESS	
Pronounced dead City Hospital		24		3424 Indiana	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie Waldhaus			4. DATE OF DEATH Month Day Year 7 16 56		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1869	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Ebenezer Dunn			14. MOTHER'S MAIDEN NAME Mary Gordon		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. K. White 327 Christian Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Right Hip; Broncho Pneumonia;					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) suffered when deceased fell out of bed at her home at 3424 Indiana Avenue on July 3rd					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW AND WHEN OCCURRED (Enter nature of injury in Part I or Part II of item 18.) bed at her home at 3424 Indiana Avenue on July 3rd				
20c. TIME OF INJURY Hour Month, Day, Year 1130 a. m. 7 3 56	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 1130 am.	20f. CITY, TOWN, OR LOCATION COUNTY STATE E902 D			
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 1100A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name or title) James M Kelly Coroner			22b. ADDRESS 1300 Clark		22c. DATE SIGNED 7-18-56
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/19/56	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) Normandy	STATE Mo.	
24. FUNERAL DIRECTOR B. Kosakowski		ADDRESS 2205 St. Louis Ave.	25. DATE RECD. BY LOCAL REG. JUL 18 1956	26. REGISTRAR'S SIGNATURE Carl Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

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 *G. W. Wilkins*

Licensed Embalmer No. *35*

P. O. Address *M. Pa.*

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.