

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15092

STATE FILE NUMBER 4269

FILED MAY 10 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 23 St. John's Hosp.		Length of stay in lb 10 days		3 rd STREET ADDRESS 6147 Columbia.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES HARRIS NICHOLSON.				4. DATE OF DEATH Month Day Year May 3, 1957.			
5. SEX Male.	6. COLOR OR RACE White.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20 1896		9. AGE (In years last birthday) 61.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President.. C.B. Nicholson Printing		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles B. Nicholson.				14. MOTHER'S MAIDEN NAME Agatha Hencke.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes. W.W.I.		16. SOCIAL SECURITY NO. 494-03-4856		17. INFORMANT Address Louise Shelton, 6147 Columbia.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Lower nephron Failure.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260x						INTERVAL BETWEEN ONSET AND DEATH 11 days	
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
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 <u>230pm 57</u> to <u>3 may 57</u> and last saw her/him alive on <u>3 may 57</u> . Death occurred at <u>8:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>C. F. Catanzaro M.D.</u>				22b. ADDRESS <u>2705 Clifton</u>		22c. DATE SIGNED <u>3 may 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 5/6/1957.		23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum.		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.,	
24. FUNERAL DIRECTOR ADDRESS C. R. Lupton & Sons, 7233 Delmar,				25. DATE RECD. BY LOCAL REG. MAY 6 '57		26. REGISTRAR'S SIGNATURE <u>J. Paul Smith M.D.</u> M.D. B.C.	

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare
Public Service
S. 300
V. 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 casually related. Coroner cannot certify to a death due to natural causes.
Securing the medical certification in the specific manner required by 193.140-140.145.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

M: 5-2517

OK

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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 *Arnold W. Schoene*

Licensed Embalmer No. 3867

P. O. Address *St. Louis*

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.