

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013028

FILED VS MAR 3 1 1960

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STATE FILE NUMBER

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 <u>MISSOURI</u> COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>LIFE</u>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>LITTLE SISTERS-OF-THE-POOR</u> INSTITUTION <u>3225-NO.FLORISSANT-AV</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>FORMERLY: 1811-NO. 18TH ST.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THEODORE NUNNEMANN</u>			4. DATE OF DEATH Month <u>MAR.</u> Day <u>15TH</u> Year <u>1960</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-1874</u>	9. AGE (last birthday) <u>86 YRS.</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN-HOME</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS - MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>FRED - NUNNEMANN</u>			13b. MOTHER'S MAIDEN NAME <u><UNKNOWN> RUEBE</u>		14. NAME OF HUSBAND OR WIFE <u><SINGLE></u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>FRED-R-MOELLER-5026-THRUSH-AV.</u>				
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>Arterio-sclerotic-heart-disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 ?</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		DUE TO (c) <u>420.0</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Subacute upper respiratory infection of 5 days duration</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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>March 9, 1960</u> to <u>March 16, 1960</u> and last saw ^{her} him alive on <u>March 14, 1960</u> Death occurred at <u>5.45 P. m</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Deceased or title) <u>Bernard H. Flotte MD</u>			22b. ADDRESS <u>2435 N. Grand Blvd</u>			22c. DATE SIGNED <u>3-16-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAR. 18-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO.</u>		
24. FUNERAL DIRECTOR <u>Brockland Und.C. 1827-HOGAN-ST.</u>			25. DATE RECD. BY LOCAL REG. <u>MAR 17 1960</u>		26. REGISTRAR'S SIGNATURE <u>Roan Smith, M.D.</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.