IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 6 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9491 STATE FILE NUMBER 60-036425

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St. Louis City Hosp. # 1
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3849 FLAD AVENUE
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Zora Middle R. Last Nickles

4. DATE OF DEATH: Month 9 Day 27 Year 60

5. SEX: Female

6. COLOR OR RACE: WHITE

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 6-28-1902

9. AGE (last birthday): 58

IF UNDER 1 YEAR: Months 2 Days 29
IF UNDER 24 HR: 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: AT HOME

11. BIRTHPLACE (City and state or country): PIKE CO. ILL.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: CHESTER TURNER

13b. MOTHER'S MAIDEN NAME: NELLIE KESSINGER

14. NAME OF HUSBAND OR WIFE: GEORGE NICKLES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: GEORGE F. NICKLES Address: 3849 FLAD AVENUE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cerebral thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c) 332+
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
Arteriosclerotic heart disease

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. 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 ☐ NOT WHILE AT WORK ☐

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 9/26/60 to 9/27/60 and last saw her/him alive on 9/27/60
Death occurred at 6:15 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John R. Hogan M.D.

22b. ADDRESS: 1515 Lafayette Ave.

22c. DATE SIGNED: 9/27/60

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

23b. DATE: 9-28-60

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State): SPRINGFIELD ILL.

24. FUNERAL DIRECTOR: THOMAS J. FINAN ADDRESS: 1519 S. GRAND BLVD.

25. DATE RECD. BY LOCAL REG.: SEP 28 1960

26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

(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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Harvey Kahle
Signature of Student Embalmer

Licensed Embalmer No. 4590

P. O. Address St Louis

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