

FILED VS NOV 3 1960

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10267

STATE FILE NUMBER

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) <b>St. Louis</b>		Length of stay in 1b <b>5 weeks</b>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>8647 Annetta</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>LYDIA</b> Middle <b>E</b> Last <b>NIENHAUS</b>				4. DATE OF DEATH Month <b>October</b> Day <b>21</b> Year <b>1960</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>9/7/1889</b>		9. AGE (last birthday) <b>71 years</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>August Besche</b>			13b. MOTHER'S MAIDEN NAME <b>Gertrude Koch</b>			14. NAME OF HUSBAND OR WIFE <b>Edward B. Nienhaus</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>—————</b>			17. INFORMANT <b>Rose Gardner - 4842 Anderson Ave</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>cerebral hemorrhage</b> <b>nephritis - hypertension - multiple cerebral hemorrhages</b> DUE TO (b) <b>Nephritis Hypertension Multiple cerebral hemorrhages</b> DUE TO (c) <b>—————</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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"/> 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 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.) <b>Aug 1960</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>10-21-60</b>			
21. I attended the deceased from <b>Aug 60</b> to <b>Oct 21-60</b> and last saw him alive on <b>Oct 21-60</b> Death occurred at <b>11 P.M. 111 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Wm. A. Knight</b> (Degree or title) <b>M.D.</b>				22b. ADDRESS <b>8201 No. Broadway</b>		22c. DATE SIGNED <b>15/10/22/60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Oct. 24, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>			
24. FUNERAL DIRECTOR <b>BUCHHOLZ MORT. - 5967 W. Florissant Ave</b>				25. DATE RECD. BY LOCAL REG. <b>OCT 24 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>			

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 W. Alfred A. Buckh

Licensed Embalmer No. 24557

P. O. Address A. L. L.

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.