

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 9 1960

-60-040652

INDEXED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3148

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BALLWIN MO</u>		Length of stay in lb <u>8 WKS</u>		c. CITY OR TOWN <u>SHREWSBERRY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PINE CREST NURSING HOME</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>7329 NOTTINGHAM</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>LUCILLE</u> Last <u>NELSON</u>				4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1960</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>4-29-1873</u>	9. AGE (last birthday) <u>87</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>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>BRUSSEL, BELGUM</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A</u>		
13a. FATHER'S NAME <u>JOHN HAART</u>			13b. MOTHER'S MAIDEN NAME <u>MARY M. GROSJEAN</u>			14. NAME OF HUSBAND OR WIFE <u>JOHN S. NELSON</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>HOWARD J. NELSON 5827 SOUTHWEST</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>Chronic Congestive Cardiac Decompensation</u> DUE TO (b) <u>arterio-sclerotic-cardio-vascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Secondary Hypertension</u>						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.) <u>none</u>						
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>9-8-59</u> to <u>10-31-60</u> and last saw her/him alive on <u>10-25-60</u> Death occurred at <u>10-31-60 4:30 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>Allen M. Nearey M.D.</u>				22b. ADDRESS <u>4308 E. Peter St. St. Louis Mo</u>		22c. DATE SIGNED <u>10-31-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE <u>10-31-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MISSOURI CREMATORY</u>		23d. LOCATION (City, town, & county) <u>ST. LOUIS MO</u>		23e. STATE <u>MO</u>			
24. FUNERAL DIRECTOR <u>HOWARD H. MICHEL 5930 SOUTHWEST</u>				25. DATE RECD. BY LOCAL REG. <u>10-31-60</u>		REGISTRAR'S SIGNATURE <u>John B. Murphy 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 *Not Embalmed*
Howard H. Michel - Funeral Director

Licensed Embalmer No. _____

P. O. Address _____

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.