

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-015990  
STATE FILE NUMBER

AMENDED FILED APR 17 1961  
Registration District No. 317 Primary Registration District No. 541 Registrar's No. 962

DATE AMENDED

INSTEAD OF:

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>ST LOUIS</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		a. STATE <u>MO</u>		b. COUNTY <u>ST. LOUIS</u>	
Length of stay in 1b <u>3 DAYS</u>		c. CITY OR TOWN <u>JENNINGS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. LOUIS COUNTY HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2513 OEPST AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Nichaus</u> Last <u>Nichaus</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1961</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>8/3/85</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
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>HOME</u>		11. BIRTHPLACE (City and state or country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM SOTMANN</u>		13b. MOTHER'S MAIDEN NAME <u>MINNIE - - - - -</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM F. NIEHAUS</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>MR. RALPH J NIEHAUS 2033 HORD AVE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Tracheo-bronchitis - severe acute.</u>							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uremia &amp; congenital absence of R kidney</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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. <u>acute multiple necrotizing @ kidney</u>		20b. <u>acute multiple necrotizing @ kidney</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>4-5-61</u> to <u>4-7-61</u> and last saw her/him alive on <u>4-7-61</u> . Death occurred at <u>2:25 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
21a. SIGNATURE <u>Albert L. Howe M.D.</u> (Degree or title)				22b. ADDRESS <u>6015 S. Brentwood Clayton, Mo</u>		22c. DATE SIGNED <u>4-2-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>4/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, Co. Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>DREHMANN HERRA 1905 UNION</u>				25. DATE RECD. BY LOCAL REG. <u>4-7-61</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

**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 Warren G. Carver

Licensed Embalmer No. 3536

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.