# SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4583 STATE FILE NUMBER 61-019308

FILED MAY 19 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Illinois b. COUNTY: Crawford
c. CITY OR TOWN: Trimble
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First WANDA Middle FAYE Last NIDEY
4. DATE OF DEATH: Month MAY Day 13 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]
8. DATE OF BIRTH: 8/2/1925
9. AGE (last birthday): 35
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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and state or country): Crawford Co., Ill.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: Pearlie Brock
13b. MOTHER'S MAIDEN NAME: Claucie Williams
14. NAME OF HUSBAND OR WIFE: Howard Nidey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
17. INFORMANT: Howard Nidey, Address: Trimble, Ill.

MEDICAL CERTIFICATION

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) | Acute Renal Failure | 3 weeks |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) | Septicemia | 3 weeks |
| DUE TO (c) | Miscarriage 651.0 | 3 weeks |

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. [X] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] 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 4/26/61, to 5/13/61 and last saw her alive on 5/13/61
Death occurred at 8:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: F R Bradley MD (Degree or title) F.R.Bradley, M. D.
22b. ADDRESS: BARNES HOSPITAL
22c. DATE SIGNED: 5/14/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 5-16-61
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Hutsonville, Ill.

24. FUNERAL DIRECTOR ADDRESS: Albert H.Hoppe, Inc., 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: MAY 15 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

**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_____ Signed Harvey Kahle

Signature of Student Embalmer

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 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.