

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-022019

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **5282**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis c. CITY OR TOWN Lemay Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 645 Allen Avenue Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Firmin Desloge Hospital Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Henry B. Nikolaisen			4. DATE OF DEATH Month Day Year May 15, 1963				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/24/1906	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Filler		10b. KIND OF BUSINESS OR INDUSTRY McDonnell Aircraft		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Henry Nikolaisen			13b. MOTHER'S MAIDEN NAME Katherine Damsen		14. NAME OF HUSBAND OR WIFE Irene York Nikolaisen		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW # 2			16. SOCIAL SECURITY NO.		17. INFORMANT Address Irene Nikolaisen 645 Allen, Lemay, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last arteriosclerotic heart disease DUE TO (b) 4200 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH instant unknown
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 type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from 5/11/63 **to** 5/15/63 **and last saw him alive on** 5/10/63
 Death occurred at 8:45 A.M. **on** the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Ernest F. Outweyer M.D.</i>	22b. ADDRESS 2623 Telegraph Rd.	22c. DATE SIGNED 5/10/63 (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 20, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town, or county) Lemay, Missouri
24. FUNERAL DIRECTOR ADDRESS C. Hoffmeister Mortuaries 781 1/2 So. Broadway St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. MAY 16 1963	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>

VS 300 Rev. 4/59	AMENDED	DATE AMENDED	ITEM NO. SHOULD READ	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	BY AFFIDAVIT OF
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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 John L. Dennehy
Licensed Embalmer No. 4194
P. O. Address St. Louis MO.

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.

Dr. Leroy Ortmeyer
2623 Telegraph Road

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