

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-022703

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1433 STATE FILE NUMBER

FILED MAY 27 1963

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>Clayton</u>		Length of stay in 1b <u>D.O.A.</u>	c. CITY OR TOWN <u>Kirkwood</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>St. Louis Co. Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>429 West Essex</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Invin</u> Middle <u>Leroy</u> Last <u>Nonfleet Sr.</u>			4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1963</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1901</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cupples Prod. Corp</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Albert S. Nonfleet</u>			13b. MOTHER'S MAIDEN-NAME <u>Jonettie Staden</u>		14. NAME OF HUSBAND OR WIFE <u>May Louis Nonfleet</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>No</u>)			16. SOCIAL SECURITY NO. <u>2</u>		17. INFORMANT <u>May L. Nonfleet</u> Address <u>429 West Essex</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) Bronchitis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) congestion breaking up, patient DUE TO (c) choked on food

INTERVAL BETWEEN ONSET AND DEATH 2 hrs

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.
 Yes No 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 <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </u>		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>April 23, 63</u> to <u>April 29, 63</u> and last saw him alive on <u>April 29, 63</u> Death occurred at <u>County Hospital</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>R.W. Fluhman D.C.</u>			22b. ADDRESS <u>11818 Olive Street rd</u>			22c. DATE SIGNED <u>5-2-63</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-2-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Gardens</u>		23d. LOCATION (City, town, or county) <u>Pagedale, Missouri</u>		
24. FUNERAL DIRECTOR <u>MITTELBERG - GERBER</u> ADDRESS <u>COLONIAL CHAPEL</u> <u>WEBSTER GROVES 10, MO</u>			25. DATE RECD. BY LOCAL REG. <u>5-2-63</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy</u>		

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 _____

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.

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