

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

OCT 23 1935

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Dr. Piquette  
Do not use this space.

29233

1. PLACE OF DEATH

County Green Registration District No. 318 File No. \_\_\_\_\_  
Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 405A  
City Springfield (No. Baptist Hospital) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

John Sherman Nash  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. Fordland Mo  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Bettie Nash

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 11 - 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 4 24

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Christiana Mo

MOTHER FATHER  
13. NAME William J Nash

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Christiana Mo

MOTHER FATHER  
15. MAIDEN NAME Mary Jane

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Salem Mo  
Cent Co Mo

17. INFORMANT E W Nash  
(ADDRESS) Fordland Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Fordland Mo DATE Sept. 6, 1935

19. UNDERTAKER Kelley - Stone  
(ADDRESS) Fordland Mo

20. FILED 9-6-35 R W Auguston  
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-4, 1935

22. I HEREBY CERTIFY, That I attended deceased from 8-22, 1935, to 8-22, 1935.  
I last saw him alive on 9-3, 1935. Death is said to have occurred on the date stated above, at 7 a.m.  
The principal cause of death and related causes of importance were as follows:

Surgical shock Date of onset 9/3/35  
Hypertrophy of prostate  
Other contributory causes of importance:  
Name of operation Prostatectomy Date of 9/2/35  
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify Robert Gynn, M. D.  
(Signed) Springfield Mo.  
(Address)

