

NOV 21 1938

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

334651  
Do not use this space.

1. PLACE OF DEATH  
(a) County Jackson Registration District No. 399  
(b) Town Kaw Primary Registration District No. 1002 Registered No. 3987  
(c) City K.C.Mo. (d) Street No. General Hospital #2 St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred \_\_\_\_\_ yrs. mos. ds. (f) How long in U.S., if of foreign birth? 31 yrs. mos. ds.

2. PRINT FULL NAME John W. Nash  
(a) Residence, No. 1008 Woodland St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Divorced  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-26-1881  
7. AGE YEARS 56 MONTHS 9 DAYS 13 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Janitor  
9. Industry or business in which work was done, as 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) Arkansas  
13. NAME Amos Nash  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
15. MAIDEN NAME Rose Murphy  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
17. INFORMANT (ADDRESS) Record Clerk General Hospital #2  
18. BURIAL, CREMATION, OR REMOVAL PLACE Highland DATE Oct. 12, 1938  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Adkins Bros 2000 E. 12th  
20. FILED Oct 12 1938 M.M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-9 1938  
22. I HEREBY CERTIFY, That I attended deceased from 9-25, 1938, to 10-9, 1938  
I last saw him alive on 10-9, 1938 Death is said to have occurred on the date stated above, at 3:40 P.M.  
The principal cause of death and related causes of importance were as follows:  
Hypertensive Type Heart Disease & De-compensation Date of onset \_\_\_\_\_  
Other contributory causes of importance: 95 B2  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
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? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) J. E. Turner, M. D.  
(Address) General Hospital #2

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.

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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 .....

Registered Apprentice No....., working under my personal supervision.

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 this body is not embalmed, above space should be left blank.**