

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 6 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24679**
Registrar's No. **43**

Registration District No. **1947** Primary Registration District No. **3035**

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Luxington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: N. 15th St 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 yrs (Specify whether years, months or days)

In this community 6 yrs

3. (a) PRINT FULL NAME SUSAN E. NASH

3. (b) If veteran, name war _____ **3. (c) Social Security** No. _____

4. Sex Female **5. Color or race** W

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Thomas Nash **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased. Oct 7 1859
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>89</u>	<u>8</u>	<u>10</u>	hr. _____ min. _____

9. Birthplace. Johnson Co Mo (City, town, or county) (State or foreign country)

10. Usual occupation. at home

11. Industry or business _____

12. Name. not known

13. Birthplace. " " " " (City, town, or county) (State or foreign country)

14. Maiden name. not known

15. Birthplace. " " " " (City, town, or county) (State or foreign country)

16. (a) Informant. C. E. Reed

(b) Address. Luxington, Mo

17. (a) Burial, cremation, or removal burial **(b) Date thereof.** 6-20-47
(Month) (Day) (Year)

(c) Place: burial or cremation. Warrsburg, Mo

18. (e) Signature of funeral director Garret J. Phipps

(b) Address. Luxington, Mo

19. (a) 6/28/47 **(b) Minera E. Conard**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

(c) City or town Luxington
(If outside city or town limits, write "RURAL")

(d) Street No. N. 15th St
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
year 1947 hour 7 minute 20 P.M.

21. I hereby certify that I attended the deceased from June 16
1947, to June 17, 1947

that I last saw her alive on June 17, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Shock caused by a fall and fracture of femur on hip

Due to fall

Other conditions none

PHYSICIAN

Major findings: X-Ray showed fracture of hip

Of operations _____

Of autopsy no

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence June 15, 47

(c) Where did injury occur? in home
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify type of place)

out of work _____ (c) Means of injury getting

23. Signature J. D. Cape **(M. D. or other)** Mo

Address Luxington **Date signed** 6/18/47

RECEIVED

District Health Officer No. 8,

Date File Number

8-5-47

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 ¹ 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, fact should be so stated above.