

No. 2
2-45
17-39
X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34215**
Registrar's No. **882**

FILED OCT 27 1947

Registration District No. **128** Primary Registration District No. **2000**

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

1. PLACE OF DEATH:

(a) County **Greene**

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

(c) Name of hospital or institution:
2140 N. Jefferson /
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME **Martha Jane Nash**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **F M /**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Widow 2**

6. (b) Name of husband or wife **John Wesley Nash Deceased**

6. (c) Age of husband or wife if **83** years

7. Birth date of deceased **October 24 1854**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	92	11	12	hr. min.

9. Birthplace **Polk County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER

12. Name **Barney Eagon**

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

14. Maiden name **Lucindia Long**

15. Birthplace **Polk County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Vera Lewis**

(b) Address **Kansas City, Missouri**

17. (a) **Burial** (b) Date thereof **10-8, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park, K.C. Mo.**

18. (a) Signature of funeral director **W.L. Dunn**

(b) Address **629 W. Walnut, Springfield, Mo.**

19. (a) **10-6-47** (b) **W.E. Handley MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene** **29**

(c) City or town **Springfield** **2**
(If outside city or town limits, write "RURAL")

(d) Street No. **2140 N. Jefferson** **1**
(If rural, give location) **No** **0**

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **6**
year **1947** hour **2** minute **43 P.M.**

21. I hereby certify that I attended the deceased from **Sept 3-47**
to Oct 3-47 that I last saw her alive on **Oct 3**, 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Altebra plegia, right**
Secularity **10 days**

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____

Of autopsy: _____

PHYSICIAN _____
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) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(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)

(e) Means of injury _____

23. Signature **Oliver A. George** (M. D. or other) **MD**
Address **Springfield Mo** Date signed **10-6-47**

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

R. J. McCann

Licensed Embalmer No.

2727

P. O. Address

Springfield 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 this body is not embalmed, fact should be so stated above.