

FILED APR 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8134

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 5466 Registrar's No. 3059

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Webster</b>					
b. CITY (If outside corporate limits, write RURAL and give township) <b>Rural—South Campbell</b>		c. LENGTH OF STAY (in this place) <b>4 Days</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Fordland</b>		112			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>OSBARK OSTEOPATHIC HOSPITAL</b>				d. STREET ADDRESS (If rural, give location) <b>1</b>					
3. NAME OF DECEASED a. (First) <b>William Henry Nash</b> (Type or Print)			b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>4-4-49</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 14, 1922</b>		9. AGE (In years last birthday) <b>26</b>	10. UNDER 1 YEAR Months	10. UNDER 1 YEAR Days	10. UNDER 1 YEAR Hours	10. UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>Wm J Nash</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Jane Simmons</b>		14. NAME OF HUSBAND OR WIFE <b>Calvin Virginia Nash Dec.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Wm Inez Jones 2123 N. Nettleton</b>				ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				19. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>3 DAY</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CIRCULATORY FAILURE</b>				DUE TO (b) <b>HYPOTENSIVE HEART DISEASE</b>					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (c) <b>CHRONIC GLOMERULONEPHRITIS OF UNKNOWN CAUSE</b>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>445X</b>		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>✓</b>					
22. I hereby certify that I attended the deceased from <b>3-31, 1949</b> , to <b>4-4, 1949</b> , that I last saw the deceased alive on <b>4-4, 1949</b> , and that death occurred at <b>2:15 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Howard J. Mason, D.O.</b>				23b. ADDRESS <b>700 E. SUNSHINE SPRINGFIELD, MO</b>		23c. DATE SIGNED <b>4-4-49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>Apr 6-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Fordland</b>		24d. LOCATION (City, town, or county) (State) <b>Fordland MO</b>				
DATE REC'D. BY LOCAL REG. <b>4/6/49</b>		REGISTRAR'S SIGNATURE <b>W.E. Hagedorn</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>W.L. Swan</b>		ADDRESS <b>Springfield, MO</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

**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 .....  
Student Embalmer

Signed *H. L. 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.