

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20081

State File No.

FILED JUL 6 1949

BIRTH NO. _____ REG. DIST. NO. 169 PRIMARY REG. DIST. NO. 4258 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY <u>Knox</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Knox</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Edina Inter.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Edina Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Nancy Ann</u> b. (Middle) <u>Sutton</u> c. (Last) <u>Sutton</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 26 1949</u>		
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5. SEX <u>F.</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>	8. DATE OF BIRTH <u>May 1 1859</u>	9. AGE (In years last birthday) <u>90</u>	IF UNDER 1 YEAR Months <u>25</u>	IF UNDER 24 HRS. Hours <u>25</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Newark Knox County Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>Henry Logan</u>	13b. MOTHER'S MAIDEN NAME <u>Elina Bradshaw</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (When, in what service) <u>No.</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Helva Sutton</u>	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>19. 1/2</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from June 25, 1949 to June 26, 1949, that I last saw the deceased alive on June 26, 1949, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Deemelius D. J.</u>	(Degree or title)	23b. ADDRESS <u>Edina Mo.</u>	23c. DATE SIGNED <u>6-27-49</u>
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24a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)	24b. DATE <u>6/28/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Catholic Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Edina Mo.</u>
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DATE REC'D BY LOCAL REG. <u>July 28-49</u>	REGISTRAR'S SIGNATURE <u>Neil S. Hurst</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Kelly</u>	ADDRESS <u>Edina Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED...

District Health Officer No.

District File Number 7-49-1

Date Filed JUL 5 1949

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.

Signed Richard B. Kelly

Signed _____
Student Embalmer

Licensed Embalmer No. 44909

P. O. Address Edina, 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.