

FILED NOV 3 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **34370**

63

BIRTH NO. _____ REG. DIST. NO. 201 PRIMARY REG. DIST. NO. 5734 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Mason Co Mo</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Mason</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Atlanta Independence</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Atlanta Mo (Rural)</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>none</u>			d. STREET ADDRESS (If rural, give location) <u>Township Independence</u>			
3. NAME OF DECEASED (Type or Print) <u>Alma</u>		a. (First)	b. (Middle)	c. (Last) <u>Nash</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 27 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED; NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 27, 1873</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hour <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Mason Co Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Samuel Nash</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Doggett</u>		14. NAME OF HUSBAND OR WIFE <u>Nannie Nash</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Nannie Nash</u> ADDRESS <u>Atlanta Mo</u>			
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, ashenia, etc.; it means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac Embarrassment.</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary congestion.</u> DUE TO (c) <u>Possible intestinal flux.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis also slight.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u> <u>Days</u> <u>Years</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>hypertension</u>		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) <u>Township Independence Mason Mo</u>			
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? <u>482X</u>			
22. I hereby certify that I attended the deceased from <u>Oct 6</u> , 19 <u>49</u> , to <u>Oct 27</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Oct 27</u> , 19 <u>49</u> , and that death occurred at <u>10³⁰ P m.</u> , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <u>George R. Yarnes H.C. 2</u>			23b. ADDRESS <u>Atlanta Mo</u>		23c. DATE SIGNED <u>Oct 28-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct 30 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>State cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Independence Township Mason Co. Mo</u>		
DATE REC'D BY LOCAL REG. <u>Oct 29 49</u>	REGISTRAR'S SIGNATURE <u>Mrs O P Ziffin</u>		186	25. FUNERAL DIRECTOR'S SIGNATURE <u>H M ...</u> ADDRESS <u>Atlanta Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 10/30/49
MACON COUNTY HEALTH DEPARTMENT
County File No. 11/1/30
Date Filed 11/1/49

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 M Goodding* _____

Licensed Embalmer No. 1750 _____

P. O. Address. *Atlanta 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.