

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35444**
8893
Registrar's No.

No. 300
10.48

FILED OCT 23 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Saline	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Mo.)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stonefort 8120	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Bessie	b. (Middle) Marie	c. (Last) Nance	10 6 51		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH August 28, 1912	9. AGE (In years last birthday) 39	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Stonefort, Ill.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME George Rawlings Duvall		13b. MOTHER'S MAIDEN NAME Edith Levo	14. NAME OF HUSBAND OR WIFE Curtis Nance		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME G.R. Duvall	ADDRESS Stonefort, Ill.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 MIN.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) RESPIRATORY FAILURE		
	ANTECEDENT CAUSES DUE TO (b) BRAIN TUMOR <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 192X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 **10-4**, **1951**, to **10-6**, **1951**, that I last saw the deceased alive on **10-6**, **1951**, and that death occurred at **3:05 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE G.B. Rader (Degree or title) M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 10-6-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-6-51	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Saline Co., Ill.
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DATE REC'D BY LOCAL REG. OCT 8 1951	REGISTRAR'S SIGNATURE J. Carl Smith, M.D., P.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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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 *Robert M. Murray*

Licensed Embalmer No. *3249*

P. O. Address

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....