

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DEC 20 1951

BIRTH NO. _____ REG. DIST. NO. **184** PRIMARY REG. DIST. NO. **3038** Registrar's No. **112**

1. PLACE OF DEATH a. COUNTY Lincoln		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Lincoln	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Brookfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Brookfield	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS 306 203 Wyatt St	
d. FULL NAME OF HOSPITAL OR INSTITUTION 203 Wyatt St			

3. NAME OF DECEASED (Type or Print) NANCY KATHERINE SIDES	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Dec-10-1951
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov-17-1865	9. AGE (in years if under 1 year, last birthday) Months Days Hours Min. 86 0 23
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10a. USUAL OCCUPATION (Give kind of work doing the most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Night 600 Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME John Hoots	13b. MOTHER'S MAIDEN NAME D K	14. NAME OF HUSBAND OR WIFE Brookly Sides
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Blairne Morrison ADDRESS Brookfield Mo
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDITIS CHRONIC		INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 4222
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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?
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22. I hereby certify that I attended the deceased from **MAY 8**, 1951, to **DEC 10**, 1951, that I last saw the deceased alive on **DEC 8**, 1951, and that death occurred at **5:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. H. Potter	23b. ADDRESS Brookfield Mo	23c. DATE SIGNED 12-11-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec-12-1951	24c. NAME OF CEMETERY OR CREMATORY Rose Hill	24d. LOCATION (City, town, or county) (State) Brookfield Mo
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DATE REC'D BY LOCAL REG. 12-13-51	REGISTRAR'S SIGNATURE Glynn Burchett	25. FUNERAL DIRECTOR'S SIGNATURE H. B. Blacklock ADDRESS Brookfield Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Date Received: DEC 17 1951
DISTRICT HEALTH OFFICE
District File Number 12-51
Date Filed: DEC 18 1951

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *J. R. Blacklock*

Licensed Embalmer No. *2246*

P. O. Address *Brookfield 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.