

FILED MAR 3 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4655

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 182

0396
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Polk	
b. CITY OR TOWN SPRINGFIELD	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN EUDORA	1849
d. FULL NAME OF HOSPITAL OR INSTITUTION SPRINGFIELD BAPTIST HOSPITAL		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print) a. (First) HORACE b. (Middle) MAYNARD c. (Last) NASH			4. DATE OF DEATH (Month) (Day) (Year) FEB. 24 52		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH SEPT 25-1874		9. AGE (In years last birthday) 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (State or foreign country) BOLIVAR Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME S. J. NASH	13b. MOTHER'S MAIDEN NAME NANCY SIMPSON	14. NAME OF HUSBAND OR WIFE NANCY NASH
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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) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME AFTON NASH	ADDRESS EL PASO TEXAS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		DUE TO (b) Benign Prostatic Hypertrophy Unknown		4 mos.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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 1-28-52	19b. MAJOR FINDINGS OF OPERATION Benign Prostatic Hypertrophy	20. AUTOPSY? YES <input 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)
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? 610X

22. I hereby certify that I attended the deceased from **Jan 3, 1952**, to **Feb. 24, 1952**, that I last saw the deceased alive on **Feb. 23, 1952**, and that death occurred at **2:10 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James T. Good M.D.	23b. ADDRESS 500 Holland Bldg. Springfield	23c. DATE SIGNED 2-24-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb 26-52	24c. NAME OF CEMETERY OR CREMATORY Pleasant Edge Cemetery Aldrich Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 2-25-52	REGISTRAR'S SIGNATURE James H. Amos M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Brim - Daniel	ADDRESS Ash Grove Mo
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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 _____

Wayne L. Daniel

Licensed Embalmer No. _____

4792

P. O. Address _____

Ash Grove, W.

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.