

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

35810

State File No.

FILED NOV 3 1952
 BIRTH NO. 70481 REG. DIST. NO. 251 PRIMARY REG. DIST. NO. 3048 Registrar's No. 239

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

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY Nodaway		b. CITY (If outside corporate limits, write RURAL and give OR TOWN Maryville)		a. STATE Missouri		b. COUNTY Nodaway	
c. LENGTH OF STAY (in this place) 2 hrs.		c. CITY (If outside corporate limits, write RURAL and give OR TOWN Maryville		d. STREET ADDRESS (If rural, give location) 323 East Second			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Francis Hospital							
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH				
a. (First) LAWRENCE	b. (Middle) NUCKOLLS		c. (Last)	Month 10	Day 20	Year 52	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 10/20/52		9. AGE (In years last birthday) 0	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryville, Missouri		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Leo Nuckolls		13b. MOTHER'S MAIDEN NAME Edna Brownfield		14. NAME OF HUSBAND OR WIFE none			
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 Leo Nuckolls, Maryville, Mo.				
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis 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.				INTERVAL BETWEEN ONSET AND DEATH 7 hrs	
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) 776 X			
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 <u>Oct. 20, 1952</u>, to <u>Oct. 20, 1952</u>, that I last saw the deceased alive on <u>Oct. 20, 1952</u>, and that death occurred at <u>12:10 P.M.</u>, from the causes and on the date stated above.							
23a. SIGNATURE <i>[Signature]</i>			(Degree or title) M. D.		23b. ADDRESS Maryville, Missouri		23c. DATE SIGNED 10-30-52
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 10/20/52	24c. NAME OF CEMETERY OR CREMATORY Oak Hill		24d. LOCATION (City, town, or county) (State) Maryville, Missouri		
DATE REC'D BY LOCAL REG. 11-1-52		REGISTRAR'S SIGNATURE <i>[Signature]</i>			25. FUNERAL DIRECTOR'S SIGNATURE Price Funeral Home, Maryville, Mo.		

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ^{not} embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *Clum M. Pucci*

Signed.....
Student Embalmer

Licensed Embalmer No. *1822*

P. O. Address *Maryville, 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.