

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 24 1952

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **1032**

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 GREENE	
b. CITY OR TOWN Springfield		c. CITY OR TOWN SPRINGFIELD 0396	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 800 E. PAGE	
d. FULL NAME OF HOSPITAL OR INSTITUTION BAPTIST HOSP.			

3. NAME OF DECEASED (Type or Print)	a. (First) JAMES	b. (Middle) VIRGIL	c. (Last) NESTOR	4. DATE OF DEATH (Month) (Day) (Year) NOV. 19, 1952
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH April 9, 1895	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE	10b. KIND OF BUSINESS OR INDUSTRY DOUGLAS AIRCRAFT CO.	11. BIRTHPLACE (City and State or Foreign Country) SPRINGFIELD, MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John J. Nestor	13b. MOTHER'S MAIDEN NAME Amanda N. Cunningham	14. NAME OF HUSBAND OR WIFE -----
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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) YES W.W. # 1	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME MRS. FLOYD SULLIVAN	ADDRESS SPRINGFIELD, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 26 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction		
	ANTECEDENT CAUSES Morbidity 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. 72 51			

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) 4201
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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?
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22. I hereby certify that I attended the deceased from **11-18-**, 19**52**, to **11-19-**, 19**52**, that I last saw the deceased alive on **11-19-52**, at **10** **A.** m., and that death occurred at **10** **A.** m., from the causes and on the date stated above.

23a. SIGNATURE Harold H. Lurie, M.D.	(Degree or title)	23b. ADDRESS Medical Arts Bldg., Springfield, Missouri	23c. DATE SIGNED 11-20-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 11-21-52	24c. NAME OF CEMETERY OR CREMATORY -----	24d. LOCATION (City, town, or county) (State) CABOOL, MISSOURI
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DATE REC'D BY LOCAL REG. 11/20/52	REGISTRAR'S SIGNATURE Edith Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE H. H. LOHMEYER	ADDRESS SPRINGFIELD, MO.
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1967 NOV 11

2281 8 2331

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 Lester T. Swadley

Licensed Embalmer No. 4815

P. O. Address Springfield

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.