

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8017**
1782

FILED MAR 11 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) Bale	
c. LENGTH OF STAY (in this place)		8130	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) Rural Route	

3. NAME OF DECEASED (Type or Print) a. (First) Nadine b. (Middle) Frances c. (Last) Timmons			4. DATE OF DEATH (Month) (Day) (Year) 2 16 53		
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 3-13-1900	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (City and State or Foreign Country) Texas		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Jerome T. Person	13b. MOTHER'S MAIDEN NAME Lou Pierce	14. NAME OF HUSBAND OR WIFE Sidney Timmons
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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 Sidney Timmons, Bale, Ill.	ADDRESS
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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 12 hrs.	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Failure acute			
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Intracranial aneurisms			3 mo.
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of rectum			5 yrs.

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)
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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? 452XH
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22. I hereby certify that I attended the deceased from **Dec. 20 19 52**, to **Feb 16**, 19**53**, that I last saw the deceased alive on **Feb. 16**, 19**53**, and that death occurred at **6:00a.m.**, from the causes and on the date stated above.

23a. SIGNATURE J. Earl Smith	(Degree or title) M. D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 2/17/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 2-16-53	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) McLeansboro, Ill.
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DATE REC'D BY LOCAL DEP. FEB 16 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Gholson F.H.,	ADDRESS McLeansboro, Ill.
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WRITE PLAINLY—USING UNFADEING 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

Ronald O Yalinski

Licensed Embalmer No. *3917*

P. O. Address *St. Louis*

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.