

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

State File No. **38892**

FILED DEC 14 1953

BIRTH NO. _____ REG. DIST. NO. **139** PRIMARY REG. DIST. NO. **5532** Registrar's No. **77**

0440

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

1. PLACE OF DEATH a. COUNTY Holt		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Holt	
b. CITY (If outside corporate limits, write RURAL and give township) Maitland - rural CLAY TWP		c. CITY (If outside corporate limits, write RURAL and give township) Maitland - rural CLAY TWP	
c. LENGTH OF STAY (in this place) 84 yrs		d. STREET ADDRESS (If rural, give location) 0440	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) Nathaniel	b. (Middle)	c. (Last) Massie	4. DATE OF DEATH (Month) (Day) (Year) 12-5-1953
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 12-14-1867	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days	IF UNDER 11 HRS. Hours Min.
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10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maitland - Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME John C. Massie	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE deceased Ella Williams Massie
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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 Will Benner	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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio Sclerosis		
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) 4201
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 **Nov 1 1953** to **12 5 1953** that I last saw the deceased alive on **12 3 1953** and that death occurred at **8:30 P. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) F. E. Hogan MD	23b. ADDRESS Mound City Mo	23c. DATE SIGNED 12 9 53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-9-1953	24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery - Maitland - Mo -	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. 12-9-1953	REGISTRAR'S SIGNATURE James Crawford	25. FEDERAL DIRECTOR'S SIGNATURE W. B. Atchison	ADDRESS Marionville 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

G. M. Etchison

Licensed Embalmer No. *2279*

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.