

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

State File No. **7567**

No. 300
10.48

BIRTH NO. **FILED FEB 23 1954** REG. DIST. NO. **360** PRIMARY REG. DIST. NO. **6225** Registrar's No. **15**

1. PLACE OF DEATH a. COUNTY Jermain		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Warren	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Warrenton		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Cadiz 0493	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION State Hospital		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Nelson b. (Middle) Fletcher c. (Last) Johnson	4. DATE OF DEATH (Month) (Day) (Year) 2-16-54
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-25-93	9. AGE (In years last birthday) 50 Months 10 Days 21 If UNDER 12 HRS. Hours Mtn.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason		10b. KIND OF BUSINESS OR INDUSTRY Contract		11. BIRTHPLACE (State or foreign country) Mo
12. CITIZEN OF WHAT COUNTRY? USA				

13a. FATHER'S NAME Louis Pericinus	13b. MOTHER'S MAIDEN NAME Lora Stephens	14. NAME OF HUSBAND OR WIFE Deo
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) No	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME Naspetal record 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, assthenia, 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) hypertensive heart disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary P.A. 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)
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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
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22. I hereby certify that I attended the deceased from **10-5-1953** to **2-6-1954**, that I last saw the deceased alive on **10-5-1953**, and that death occurred at **1:35P** m., from the causes and on the date stated above.

23a. SIGNATURE R. E. Hall M.D. (Degree or title)	23b. ADDRESS Nevada Mo	23c. DATE SIGNED 2-16-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 2-19-54	24c. NAME OF CEMETERY OR CREMATORY PARK CEMETERY	24d. LOCATION (City, town, or county) (State) CADIZ, MO
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DATE REC'D BY LOCAL REG. 2-18-1954	REGISTRAR'S SIGNATURE Anna E. Ferriss	25. FUNERAL DIRECTOR'S SIGNATURE WALTER FUNERAL HOME ADDRESS CADIZ MO
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(Licensed Emballer's Statement on Reverse Side)

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

80
2

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 _____

Edwin L. Thayer, Jr.

Licensed Embalmer No. *4955*

P. O. Address *Carthage, 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.