

FILED SEP 23 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31108

State File No. 154

BIRTH NO. _____		REG. DIST. NO. 170		PRIMARY REG. DIST. NO. 3033		Registrar's No. 154	
1. PLACE OF DEATH a. COUNTY Laclede				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Mo b. COUNTY Laclede			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lebanon		c. LENGTH OF STAY (in this place) ✓		c. CITY OR TOWN Lebanon		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION 225 Garfield				STREET ADDRESS (If rural, give location) 225 Garfield 0532			
3. NAME OF DECEASED (Type of Print) a. (First) Nellie		b. (Middle) J		c. (Last) Atchley		4. DATE OF DEATH (Month) (Day) (Year) Sept. 7 1954	
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH April 3 1881	
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME John Prescott		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE John E. Atchley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ted Brown Lebanon Mo.		ADDRESS	
18. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 days	
19a. DATE OF OPERATION		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)	
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?		22. I hereby certify that I attended the deceased from 3-2-, 1954, to 9-7-, 1954, that I last saw the deceased alive on 9-7-, 1954, and that death occurred at 1:30 P.M., from the causes and on the date stated above.	
23a. SIGNATURE B.B. Hurst, M.D.		23b. ADDRESS Lebanon Mo.		23c. DATE SIGNED 9-9-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 9-10-1954		24c. NAME OF CEMETERY OR CREMATORY Fulbright		24d. LOCATION (City, town, or county) (State) Laclede Co Mo.		25. FUNERAL DIRECTOR'S SIGNATURE S.P. Palmer	
DATE REC'D BY LOCAL REG. 9-11-1954		REGISTRAR'S SIGNATURE Hella L. May		ADDRESS Lebanon Mo.		(Licensed Embalmer's Statement on Reverse Side)	

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

Received -----
Laclede County Health Unit
File No. -----
Date Filed -----
SEP 19 1954
9-54-149
SEP 22 1954

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 -----
Signature of Student Embalmer

Signed *S. R. Palmer*

Licensed Embalmer No. *22*

P. O. Address *Channah*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.