

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35772

8734

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>St. Louis, Mo.</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>11 1805 Sarah No 21190</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jack</u> b. (Middle) _____ c. (Last) <u>Nash</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 22 54</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug, 8th?</u>	
9. AGE (In years, just birthdays) <u>44</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Texarkana Ark.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>Robert Nash</u>		13b. MOTHER'S MAIDEN NAME <u>Channy ?</u>		14. NAME OF HUSBAND OR WIFE <u>Cora Nash</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Cora Nash</u>		ADDRESS <u>4014 Evans</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Benign Prostatic Hypertrophy with Intractable Hematuria</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undt.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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? <u>610X</u>			
22. I hereby certify that I attended the deceased from <u>8-17</u> , 19 <u>54</u> , to <u>9-22</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>9-22</u> , 19 <u>54</u> , and that death occurred at <u>11:05P.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Morris Abrams M.D.</u>				23b. ADDRESS <u>2601 N. Whittier</u>		23c. DATE SIGNED <u>9-24-54</u>	
24a. BURIAL, CREMATION, OR OTHER DISPOSITION <u>Emmeped</u>		24b. DATE <u>9-25-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Texarkana, Ark.</u>		24d. LOCATION (City, town, or county) (State) <u>Texarkana, Ark.</u>	
DATE REC'D BY LOCAL REG. <u>SEP 25 1954</u>		REGISTRAR'S SIGNATURE <u>E. L. Beal</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>A. L. Beal Und Co. 4303 Delmar</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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.....
Signature of Student Embalmer

Signed *Samuel W. Hughes*.....

Licensed Embalmer No. *480*.....

P. O. Address *3123 90*.....

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.