

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9151

State File No. ....

FILED MAR 22 1955

BIRTH NO. 16310-55 REG. DIST. NO. 290 PRIMARY REG. DIST. NO. 5985 Registrar's No. 28

1. PLACE OF DEATH a. COUNTY <b>Pulaski</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Pulaski</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Fort Leonard Wood</b>		c. LENGTH OF STAY (in this place) <b>0</b>	c. CITY OR TOWN <b>Waynesville</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>US Army Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		f. STREET ADDRESS (If rural, give location) <b>Rural Route #2</b>	

3. NAME OF DECEASED (Type or Print) <b>Nancy Sue</b>		a. (First) <b>Nancy</b> b. (Middle) <b>Sue</b> c. (Last) <b>Ichord</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>March 10, 1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>10 March 1955</b>	
9. AGE (In years last birthday) <b>10</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Fort Leonard Wood, Missouri</b>	
13a. FATHER'S NAME <b>Roy W. Ichord</b>		13b. MOTHER'S MAIDEN NAME <b>Bessie L. Ashworth</b>		14. NAME OF HUSBAND OR WIFE <b>N/A</b>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>ROBERT STALEY, 2/11/55</b>	
				ADDRESS <b>US Army Hospital Ft Leonard Wood, Mo</b>	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary engorgement</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
		ANTECEDENT CAUSES Intake of amniotic fluid at first Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>act of inspiration</b>			
		DUE TO (c) <b>Posterior position</b>			
		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 <b>7620</b>		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?	

22. I hereby certify that I attended the deceased from 10 March, 1955, to 10 March, 1955, that I last saw the deceased alive on 10 March, 1955, and that death occurred at 3:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE <b>DAVID J. GRIFFIN</b> (Degree or title)		23b. ADDRESS <b>US Army Hospital Fort Leonard Wood, Missouri</b>		23c. DATE SIGNED <b>10 Mar 1955</b>	
24a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11 Mar 55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Crocker Memorial</b>	
24d. LOCATION (City, town, or county) (State) <b>Crocker Missouri</b>		24e. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Hedges</b>		24f. ADDRESS <b>HEDGES FUNERAL HOMES INC CROCKER MO</b>	

DATE REC'D BY LOCAL REG. <b>3-11-55</b>		REGISTRAR'S SIGNATURE <b>Paula E. Anderson</b>		4555	
--	--	---	--	------	--

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

RECEIVED  
3-11-55  
Alaska County Health Officer  
File Number 19  
Date Filed 3-18-55

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.....  
*Clarence Jones*

Licensed Embalmer No. *4884*  
P. O. Address *W. J. Jones, Inc.*

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.