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FILED FEB 24 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-008458

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Shackelford</u> <u>0970</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>678 So. Odell</u>		Length of stay in lb <u>5 weeks</u>	d. STREET ADDRESS (If outside, give location) <u>Elmwood township</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Duncan</u> Last <u>Heins</u>	4. DATE OF DEATH Month <u>Feb.</u> Day <u>17th</u> Year <u>1958</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17th 1912</u>	9. AGE (In years last birthday) <u>45</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>Saline County Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>William Duncan</u>	13b. MOTHER'S MAIDEN NAME <u>Ola Fetty</u>	14. NAME OF HUSBAND OR WIFE <u>Leo Heins</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>500-03-8588</u>	17. INFORMANT <u>Leo Heins, Shackelford Mo. Route No. 1</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis,</u> DUE TO (b) <u>Malnutrition.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Months.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Marshall Mo.</u>	COUNTY <u>Marshall</u>	STATE <u>Missouri</u>
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21. I attended the deceased from <u>Dec - 1957</u> to <u>Feb. 17, 1958</u> and last saw her alive on <u>Feb. 17, 1958</u> Death occurred at <u>11-35 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>P. L. Lawless M.D.</u>	22b. ADDRESS <u>Marshall Mo.</u>	22c. DATE SIGNED <u>2-19-58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-20-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park cemetery</u>	23d. LOCATION (City, town, or county) <u>Marshall Missouri</u>	(State)
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24. FUNERAL DIRECTOR <u>Campbell-Lewis, Marshall Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>2-19-58</u>	26. REGISTRAR'S SIGNATURE <u>Carl P. Reed</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *James A. Lewis*

Licensed Embalmer No. *4709*

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