

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033931
STATE FILE NUMBER

FILED SEP 20 1958 Registration District No. 316 Primary Registration District No. 4462 Registrar's No. 361

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| 1. PLACE OF DEATH a. COUNTY <u>ST. FRANCOIS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. FRANCOIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELVINS</u> | | c. CITY OR TOWN <u>Flat River,</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BENHAM NURSING HOME WA</u> | | d. STREET ADDRESS (If outside, give location) | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| Length of stay in lb | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|---|----------------------------------|---|--|--|---|---|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>NANCY Jane DOSING</u> | | | 4. DATE OF DEATH Month Day Year <u>SEPT. 15/1958</u> | | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 17, 1870</u> | | 9. AGE (In years last birthday) <u>80</u> F UNDER 1 YEAR Months Days F UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>BISMARCK, MO.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |

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| 13a. FATHER'S NAME <u>George Whaley</u> | | 13b. MOTHER'S MAIDEN NAME <u>Bellia (UNKNOWN)</u> | | 14. NAME OF HUSBAND OR WIFE <u>JOHN DOSING</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>NONE</u> | | 17. INFORMANT Address <u>Alma Ford St. Louis Mo</u> | | | |

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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>(a) Acute Circulatory Failure</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>6 hr.</u> <u>24 hr.</u> <u>6 days</u> |
| DUE TO (b) <u>(b) Cerebral Anoxia</u> | | | | |
| DUE TO (c) <u>(c) Hypostatic pneumonia</u> | | | | |
| DUE TO (c) <u>(d) Accidental Fracture of Neck of Rt. Femur - Following a Fall at bedside of Benham Nursing Home Elvins, Mo. on 9-9-1958</u> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>9037 14</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input checked="" 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.) <u>Pt. was standing at her bedside & Fall when she started to walk across the room.</u> | |
| 20c. TIME OF INJURY Hour Month, Day, Year <u>7:30 Sept. 9 1958</u> | | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u> | |

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| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/> | | 20f. CITY, TOWN, OR LOCATION <u>Elvins, St. Francois, Mo.</u> | |
| 21. I attended the deceased from <u>9-9-1958</u> to <u>9-15-1958</u> and last saw her alive on <u>9-15-1958</u> Death occurred at <u>9:00 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) <u>W.D. Morris, D.O.</u> | |
| 22b. ADDRESS <u>Flat River, Mo.</u> | | 22c. DATE SIGNED <u>9-15-1958</u> | |

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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>SEPT. 17, 1958</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>W. OF P.</u> | | 23d. LOCATION (City, town, or country) (State) <u>Flat River, MO</u> | |
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| 24. FUNERAL DIRECTOR <u>Raymond Caldwell</u> | | 25. DATE RECD. BY LOCAL REG. <u>Sept. 15, 1958</u> | | 26. REGISTRAR'S SIGNATURE <u>Cather Rudloff</u> | |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *R. Caldwell*

Licensed Embalmer No. *2531*
P. O. Address *Flat River, Va.*

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.