Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002211
STATE FILE NUMBER

FILED FEB 3 1959 Registration District No. 23 Primary Registration District No. 5812 Registrar's No. 1

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Prairie Twp. — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): — Length of stay in 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Montg
c. CITY OR TOWN: Middletown — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): 1 Mi. E — Reside on Farm: Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First: Nevie Middle: Ann Last: Laird

4. DATE OF DEATH: Month: Jan. Day: 27 Year: 1959

5. SEX: F **6. COLOR OR RACE**: White **7.** MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 5 1886 **9. AGE** (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife **10b. KIND OF BUSINESS OR INDUSTRY**:

11. BIRTHPLACE (City and state or country): Frankford Mo. **12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

13a. FATHER'S NAME: John Inlow **13b. MOTHER'S MAIDEN NAME**: Anna Sinklear **14. NAME OF HUSBAND OR WIFE**: Elijah Taylor Laird

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None **17. INFORMANT**: Hazel Summers Address: 5585 Etzel St Louis

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 4261

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐ **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ **20e. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **20f. CITY, TOWN, OR LOCATION** COUNTY STATE

21. I attended the deceased from Jan 10, 1959 to Jan 27, 1959 and last saw her alive on Jan 10, 1959
Death occurred at hour 8:30 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): William H. Waller D.O. **22b. ADDRESS**: Willsville Mo **22c. DATE SIGNED**: 1/28/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial **23b. DATE**: Jan. 30 1959 **23c. NAME OF CEMETERY OR CREMATORY**: Eolia Cemetery **23d. LOCATION** (City, town, or county): Eolia (State): Mo.

24. FUNERAL DIRECTOR: Butler & Pritchett **ADDRESS**: Middletown Mo **25. DATE RECD. BY LOCAL REG.**: Jan. 29, 1959 **26. REGISTRAR'S SIGNATURE**: Mrs. Zoe Chapman.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 George O. Wagner

Licensed Embalmer No. 3773

P. O. Address Louisiana

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.