Dr. McDonald

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014333

STATE FILE NUMBER

FILED MAY 15 1959 Registration District No. 272 Primary Registration District No. 4403 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY Pemiscot	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pemiscot
b. CITY OR TOWN Steele — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Steele 0780 — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) — Length of stay in lb 15 yrs	d. STREET ADDRESS (If outside, give location) Twigg Dr. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Nellie Washington

4. DATE OF DEATH Month Day Year: 4-28-59

5. SEX: F 3

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 2

8. DATE OF BIRTH: Unknown Abt 74

9. AGE (In years last birthday) 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): Home Work

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Vaden Miss

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: Unknown

13b. MOTHER'S MAIDEN NAME: Unknown

14. NAME OF HUSBAND OR WIFE: —

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

16. SOCIAL SECURITY NO.:

17. INFORMANT: Will Baker — Address: Steele Mo

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): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331x

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 0

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 4-~~26~~ 36-59, to 4-28-59 and last saw her/him alive on 4-26-59

Death occurred at 5:25 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H. M. McWaniel Mo

22b. ADDRESS: Steele Mo

22c. DATE SIGNED: 6-2-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 5-3-59

23c. NAME OF CEMETERY OR CREMATORY: Holly Grove

23d. LOCATION (City, town, or county) (State): Steele Mo

24. FUNERAL DIRECTOR: Vernon Funeral Home — ADDRESS: Steele Mo

25. DATE RECD. BY LOCAL REG.: 5-9-59

26. REGISTRAR'S SIGNATURE: [signature]

(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

MAY 13 1959

CARUTHERSVILLE, MO.

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 Noel C Dean

Licensed Embalmer No. 3941

P. O. Address Caruthers

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.