

# REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028253

FILED VS SEP 14 1959 042

1000

913

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Buchanan</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Length of stay in 1b <u>47 years</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Meth. Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u> c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1701 Highly Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CHARLES JAMES NESMITH</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>September 5, 1959</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Caucasian</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11/22/1892</u>	<b>9. AGE</b> (last birthday) <u>66 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Brick Mason</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Lehr Const't Co.</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Shenandoah, Iowa</u>			
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>James Nesmith</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Clara Martin</u>			
<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mrs. Mary V. Nesmith</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W. # 1</u>		<b>16. SOCIAL SECURITY NO.</b> <u>491-09-3678</u>			
<b>17. INFORMANT</b> Address <u>Mr. Guy T. Nesmith, Shenandoah, Iowa</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>A.S.H.D.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY STATE</b>			
<b>21. I attended the deceased from</b> <u>4 Sept.</u> to <u>5 Sept.</u> and last saw him alive on <u>5 Sept.</u> Death occurred at <u>8:20 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Wilbur C. McDonald M.D.</u>			<b>22b. ADDRESS</b> <u>301 N. 8<sup>th</sup> St. St. Joseph</u>		<b>22c. DATE SIGNED</b> <u>8 Sept 59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>		<b>23b. DATE</b> <u>9/8/1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Shenandoah Iowa</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Stoney Funeral Home St. Joseph, Mo.</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>Sept. 10, 1959</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs. Clark Goodell</u>			

DOCUMENT

BY AFFIDAVIT OF W. P. McDonald, M.D. MEDICAL CERTIFICATION

SEP 16 1950

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *E. Macaul*

Licensed Embalmer No. 4238

P. O. Address St. Joe

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.