RI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

XC-4596 56 FILED VS AUG 3 1 1959

59-031107
STATE FILE NUMBER

Registration District No. 37 Primary Registration District No. 500 Registrar's No. 2265

DED

1. PLACE OF DEATH
a. COUNTY: ST. LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: JEFFERSON BARRACKS, MO.
Length of stay in 1b: 619 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VETERANS ADMINISTRATION HOSP.
Inside Limits: Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: NEW MADRID
c. CITY OR TOWN: MARSTON
Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): BOX 171
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First HERSHEL Middle MAYS Last NANNEY
4. DATE OF DEATH: Month 8 Day 20 Year 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1929-10
9. AGE (last birthday): 49
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARNIVAL WORKER
10b. KIND OF BUSINESS OR INDUSTRY: CARNIVAL
11. BIRTHPLACE (City and state or country): HAYTI, MISSOURI
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: ELISHA NANNEY
13b. MOTHER'S MAIDEN NAME: HADDIE M. NEWTON
14. NAME OF HUSBAND OR WIFE: ----------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW-2
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: VA HOSPITAL RECORDS, JEFFERSON BARRACKS, MO Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	FEW MIN.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	ARTERIOSCLEROTIC HEART DISEASE	2 YRS.
DUE TO (c)		

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

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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

I/VA attended the deceased from 12-9-57, to 8-20-59 and last ~~XXXXXXXXXXXX~~

Death occurred at 12:30 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Anthony Cerskus M.D. (Degree or title) ANTHONY CERSKUS M.D.
22b. ADDRESS: VA HOSP. JEFFERSON BARRACKS, MO.
22c. DATE SIGNED: 8-20-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 8-22-59
23c. NAME OF CEMETERY OR CREMATORY: Mounds Park Cemetery
23d. LOCATION (City, town, or county) (State): New Madrid, Mo.

24. FUNERAL DIRECTOR ADDRESS: Richards Funeral Service, New Madrid, Mo.
25. DATE REC'D. BY LOCAL REG.: 8-21-59
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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