

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-031709

FILED VS OCT 6 1959

STATE FILE NUMBER

Registration District No. 53 Primary Registration District No. 3009 Registrar's No. 342

S. 300
v. 1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH COUNTY <u>Cape Girardeau</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cape Girardeau</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jackson Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Jackson Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deal Nursing Home</u>		Length of stay in lb <u>8da</u>	d. STREET ADDRESS <u>303 W. Adams</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>V.</u> Last <u>Niblack</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1959</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30 1879</u>		9. AGE (In years last birthday) <u>80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keeping House</u>	11. BIRTHPLACE (City and state or country) <u>Jackson Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>B. L. Niblack</u>		13b. MOTHER'S MAIDEN NAME <u>Armintha e. Rose</u>		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) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>John A. Niblack Burfordville</u>		
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>Arteriosclerotic Heart Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
Conditions, if any, which gave rise to above cause (a), stating the under- lying 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) <u>3-4-200</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		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 <u>June 27, 1951</u> to <u>Sept 22, 1959</u> and last saw her <u>alive</u> on <u>Sept 21, 1959</u> Death occurred at <u>8:30</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. H. Jaeger, M.D.</u> (Degree or title)			22b. ADDRESS <u>Jackson, Mo</u>		22c. DATE SIGNED <u>Sept 23, 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Russell Heights</u>		23d. LOCATION (City, town, or county) <u>Jackson Mo.</u> (State)	
24. FUNERAL DIRECTOR <u>Deneke-Laird Jackson Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>9-29-1959</u>		26. REGISTRAR'S SIGNATURE <u>Gene Harten</u>	

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. O. Laine

Licensed Embalmer No. 4538

P. O. Address Jackson, Mo.

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.