

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000069

FILED VS FEB 8 1960

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Registration District No. _____ Primary Registration District No. **3002**

Registrar's No. **33**

STATE FILE NUMBER

DED

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|--|--|---|---|---|---|--|---|----------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Andrain | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Andrain | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mexico | | Length of stay in 1b | | c. CITY OR TOWN Mexico | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Andrain Co Hosp | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 802 E Holt | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Henry Middle - Last Nickens | | | | 4. DATE OF DEATH Month JANUARY Day 31 Year 1960 | | | | | |
| 5. SEX male | | 6. COLOR OR RACE negro | | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH Mar 26, 1906 | | 9. AGE (last birthday) 53 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph operator | | 10b. KIND OF BUSINESS OR INDUSTRY Telegraph Co. | | 11. BIRTHPLACE (City and state or country) MARTINSBURG MO | | 12. CITIZEN OF WHAT COUNTRY U S A. | | | |
| 13. FATHER'S NAME George Nickens | | | 13b. MOTHER'S MAIDEN NAME Glice Remack | | | 13c. NAME OF HUSBAND OR WIFE Mrs Max. Taylor | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO. 491-05-5903 | | 17. INFORMANT Name Mrs Max. Taylor Address Mexico Mo | | | | |
| 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 Vasculature | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis | | | | | | | years | | |
| DUE TO (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (not related to the terminal illness condition given in PART I) Generalized arteriosclerosis Hypertension | | | | | | 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 | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ Month, Day, Year _____ p.m. | | | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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 1956 to 1-31-1960 and last saw him alive on 1-31-60 Death occurred at 11:45 AM m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Edward Stover MD | | | | 22b. ADDRESS Mexico Mo | | | 22c. DATE SIGNED 2-3-60 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Feb 5-1960 | | 23c. NAME OF CEMETERY OR CREMATORY ELMWOOD CEMETERY | | 23d. LOCATION (City, town, or county) (State) MARTINSBURG, MO | | | |
| 24. FUNERAL DIRECTOR Mrs. Stuart Parker Columbia | | | | 25. DATE RECD. BY LOCAL REG. Feb 4-1960 | | 26. REGISTRAR'S SIGNATURE Blanche Reely | | | |

DOCUMENT

MEDICAL CERTIFICATION

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 _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George D. Keamm

Licensed Embalmer No. 442

P. O. Address Calumet

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.