

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 8 1960

=60-000214

Registration District No. 38 Primary Registration District No. 2006 Registrar's No. 59

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia, Mo.</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone County Hospital</u> Inside Limits <input 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>Cole</u> c. CITY OR TOWN <u>Jefferson City, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>328 Ash Str</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>John Andrew Nancy</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>Jan 29, 1960</u>				
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input checked="" type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>6/5/88</u>	<b>9. AGE</b> (last birthday) <u>71</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>21</u> Hours _____ Min. _____ IF UNDER 24 HR		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Auditor State Highway Dept</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>State Highway Dept</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Jefferson City, Mo. USA</u>			
<b>13a. FATHER'S NAME</b> <u>Peter Nancy</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Honora Collins</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>None</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 War I</u>		<b>16. SOCIAL SECURITY NO.</b> <u>492-36-8377</u>		<b>17. INFORMANT</b> Address <u>Patricia Nancy J C Mo.</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>Uremia (Post operative Suprapubic Prostatectomy)</u> INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> DUE TO (b) <u>Uremian Distention +</u> <u>infection</u> <u>2 years</u> DUE TO (c) <u>Enlarged Prostate Gland</u> <u>2 years</u> 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"/> - <b>NOT WHILE AT WORK</b> <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</b> _____ <b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>12-15-59</u> to <u>1-29-60</u> and last saw her/him alive on <u>1-28-60</u> Death occurred at <u>3:40 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>James C. Cefel, M.D.</u>			<b>22b. ADDRESS</b> <u>709 University</u>		<b>22c. DATE SIGNED</b> <u>Feb 60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>2/1/60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peters</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Jefferson City, Mo.</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Sylvester Green</u>			<b>25. DATE RECD. BY LOCAL REG.</b> <u>J C Mo. Feb 5 1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs R E Palmer</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

YS FEB 23 1960

**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 Sylvester Quill

Licensed Embalmer No. 4321

P. O. Address Jefferson Ave

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.