

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000215

STATE FILE NUMBER

FILED VS FEB 15 1960

35

Registration District No. _____ Primary Registration District No. 3006

Registrar's No. 83

DED

1. PLACE OF DEATH a. COUNTY <u>Boone</u> b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Length of stay in 1b <u>2 wks</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>B. County Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u> c. CITY OR TOWN <u>Columbia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>705 N. 6th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>(none)</u> Last <u>Nauser</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>8</u> Year <u>1960</u>														
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1872</u>	9. AGE (last birthday) <u>87</u>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HR</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HR		Months	Days	Hours	Min.				
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Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>											
13a. FATHER'S NAME <u>Florian Nauser</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Ella Nauser (dec.)</u>												
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> </u>		17. INFORMANT Address <u>Mrs Clarence Jones Hallsville</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>Fractured hip</u> Conditions, if any, which gave rise to above cause (a), stating the underlying 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) 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 INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fall at home (nursing Home)</u>														
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u>Jan 60</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>home (nursing)</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Columbia, Mo.</u> <u>Boone</u> <u>Mo.</u>											
21. I attended the deceased from <u>Jan 1960</u> to <u>2-8-60</u> and last saw her/him alive on <u>2-7-60</u> Death occurred at <u>Feb. 8, 1960, 9:00 a</u> m on, the date stated above, and to the best of my knowledge, from the causes stated.																	
22. SIGNATURE (Degree of title) <u>William J. Stewart, MD</u>				22b. ADDRESS <u>Columbia, Mo.</u>		22c. DATE SIGNED <u>2-9-60</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/10/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Boone County, Mo.</u>											
24. FUNERAL DIRECTOR ADDRESS <u>Lyman Sprinkle Columbia, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Feb 10 1960</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>												

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

Student _____
Signature of Student Embalmer

Signed George D. Rams

Licensed Embalmer No. 4425

P. O. Address Columbia

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