

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 26 1960

-60-003062

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 20

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois</u>		Length of stay in 1b		c. CITY OR TOWN <u>Bismarck</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>Mineral Area Osteo. Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Bismarck</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE FLORENCE LOGAN</u>				4. DATE OF DEATH Month Day Year <u>Jan. 16 1960</u>				
5. SEX <u>fem</u>	6. COLOR OR RACE <u>white</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>12-1-1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (City and state or country) <u>Iron County Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>John A. Logan</u>			13b. MOTHER'S MAIDEN NAME <u>Lenora E. Neely</u>			14. NAME OF HUSBAND OR WIFE <u>##</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>no</u>		17. INFORMANT <u>L. E. Logan, Bismarck Mo.</u>			Address
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) <u>Congestive Circulatory Failure</u>							<u>Immediate</u>	
DUE TO (b) <u>Decompensated Hypertensive Heart Disease</u>							<u>Years</u>	
DUE TO (c) <u>Arteriosclerosis</u>							<u>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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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. Month, Day, Year								
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 <u>March 26, 1959</u> to <u>Jan. 15, 1960</u> and last saw her alive on <u>Jan. 16, 1960</u> Death occurred at <u>2:15 A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>M. M. Beck D.O.</u>				22b. ADDRESS <u>Bismarck, Missouri</u>			22c. DATE SIGNED <u>1-16-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>burial</u>		<u>1-17-60</u>	<u>Masonic Cemetery</u>		<u>Bismarck, Mo.</u>			
24. FUNERAL DIRECTOR <u>White Funeral Home, Bismarck Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Jan 16, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Esther Rudloff</u>		

(Licensed Embalmer's Statement on Reverse Side)

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 Arnell J. White

Licensed Embalmer No. 3017

P. O. Address Ormiton N

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