

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006792

FILED VS. MAR. 9 1960

157

Registration District No. **3028**

Primary Registration District No. **50**

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY Jasper				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE Mo. b. COUNTY Jasper									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Length of stay in 1b 24 yrs		c. CITY OR TOWN Carthage		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION McCune-Brooks hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 310 W. 5th St		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Samuel Middle Nation Last Nation				4. DATE OF DEATH Month Feb Day 26 Year 1960									
5. SEX male		6. COLOR OR RACE white		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-14-1876		9. AGE (last birthday) 83		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer				10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (City and state or country) Charleston, Ill		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Norris Nation				13b. MOTHER'S MAIDEN NAME Nancy Higginbotham				14. NAME OF HUSBAND OR WIFE Effie Goode Nation					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes Span-American				16. SOCIAL SECURITY NO. none		17. INFORMANT Effie Nation, 310 W. 5th, Carthage, 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) Acute Coronary occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH approx 9 da			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) atrial fibrillation										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 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 2-17-60 to 2-26-60 and last saw ^{her} him alive on 2-26-60 Death occurred at 8:15 ^h m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Richard R. Coyle (Degree or title) MD				22b. ADDRESS Carthage, Mo				22c. DATE SIGNED 2-27-60					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2-29-60		23c. NAME OF CEMETERY OR CREMATORY Park Cemetery		23d. LOCATION (City, town, or county) Carthage, Mo		(State)					
24. FUNERAL DIRECTOR Knell Mortuary, Carthage, Mo				25. DATE RECD. BY LOCAL REG. 2-28-60		26. REGISTRAR'S SIGNATURE W. Cloutier							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 11 1960

MAR 9

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 Frank W. Kuehl

Licensed Embalmer No. 4440

P. O. Address Carthage, 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.