

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
EILED VS MAR 25 1960

60-013022

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2908** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN Turtle		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Route 3		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dolph W. Nivens				4. DATE OF DEATH Month Day Year March 10, 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 5/11/1896	9. AGE (last birthday) 63	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister - Retired			10b. KIND OF BUSINESS OR INDUSTRY Dent Co., Mo.		11. BIRTHPLACE (City and state or country) U.S.		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME James Nivens			13b. MOTHER'S MAIDEN NAME Amy Cape			14. NAME OF HUSBAND OR WIFE Olie Nivens		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address James Dixon, 1332 Belvue - Pagedale, 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 Thrombosis old and recent							INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis							years	
DUE TO (c) 332+								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Aortic Stenosis, congestive heart failure					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 checked="" 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 a.m. 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 3/6/60 to 3/10/60 and last saw ^{her} him alive on 3/10/60 Death occurred at 12:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Robert A. Mayer MD				22b. ADDRESS 950 Francis Place, Clayton 5.			22c. DATE SIGNED 3-11-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-13-60	23c. NAME OF CEMETERY OR CREMATORY Stonehill Cemetery		23d. LOCATION (City, town, or county) Stone Hill, Mo.		23e. (State)		
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. MAR 12 1960		26. REGISTRAR'S SIGNATURE Neal Smith M.D. (H-T)		

INDEXED

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 Clarence M. Beck

Licensed Embalmer No. 4375

P. O. Address St. Louis, 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.