

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED MAR 30 1960

60-013640

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1018

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Wellston</u>		Length of stay in 1b <u>31 yrs. 7 mos.</u>	c. CITY OR TOWN <u>Wellston (Rural)</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Vincent's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>7301 St. Charles Rock</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>MESSMAN</u> Last <u>MESSMAN</u>			4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1960</u>		
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5. SEX <u>Female</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>8/18/68</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Kankakee, Illinois</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Hyacinth Ray</u>	13b. MOTHER'S MAIDEN NAME <u>Sophia Rivard</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</u>
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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>Unknown</u>	17. INFORMANT Address <u>Records of St. Vincent's Hospital</u>
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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>Broncho Pneumonia</u>	<u>24 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Spontaneous Fracture - Left Femur</u>	<u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</u> <u>Generalized Arteriosclerosis</u>		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.)
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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
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21. I attended the deceased from Jan. 1, 1948 to March 26, 1960 I last saw ^{her} live on March 26, 1960
 Death occurred at 1:55 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>[Signature]</u> (Degree or title)	22b. ADDRESS <u>7301 St. Charles Rock Rd.</u>	22c. DATE SIGNED <u>3/26/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/27/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL</u>	23d. LOCATION (City, town, or county) (State) <u>Kentland Indiana</u>
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24. FUNERAL DIRECTOR <u>Callie Kelly</u> ADDRESS <u>7267 Natural Bridge</u>	25. DATE RECD. BY LOCAL REG. <u>3-26-60</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
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(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 James A. Lamm
Licensed Embalmer No. 414

P. O. Address St. Louis

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.