

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027911

FILED VS JUL 28 1960

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 107

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Dade</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ft. Leonard Wood, Mo.</u>			Length of stay in 1b		c. CITY OR TOWN <u>Miami 58</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>US Army Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>14200 Carver Dr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Nannette</u> Middle <u>---</u> Last <u>Devone</u>				4. DATE OF DEATH Month <u>Jul</u> Day <u>20</u> Year <u>60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negroid</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-3-15</u>	9. AGE (last birthday) <u>44</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (City and state or country) <u>Carthage, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Deceased</u>			13b. MOTHER'S MAIDEN NAME <u>Deceased</u>			14. NAME OF HUSBAND OR WIFE	
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 <u>John T. Odom</u>		Address <u>Ft. Leonard Wood, Mo.</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>Bowel obstruction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinomatosis of ovary</u>						<u>5 years</u>	
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 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 _____ 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 <u>30 Jun 60</u> to <u>20 Jul 60</u> and last saw her <u>alive</u> on <u>20 Jul 60</u> Death occurred at <u>12:25 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Type name and title) <u>Charles J. Koucky, Capt, MC</u>				22b. ADDRESS <u>Ft. Leonard Wood, Mo.</u>		22c. DATE SIGNED <u>7-20-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7/22/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARADISE MEMORIAL GARDEN</u>		23d. LOCATION (City, town, or county) (State) <u>Miami Florida</u>		
24. FUNERAL DIRECTOR <u>Hedges FUNERAL HOME CROCKER</u>			25. DATE RECD. BY LOCAL REG. <u>7-20-60</u>		26. REGISTRAR'S SIGNATURE <u>Emilia M. Anderson</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 28 1960

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**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 Pross*

Licensed Embalmer No. 4896

P. O. Address Waynesville

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.