

JURISDICTION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030050

FILED VS SEP 12 1960

82

3017

124

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Cooper				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Cooper									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Boonville		Length of stay in 1b 1 wk		c. CITY OR TOWN Boonville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 120 W. Water St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First James Middle H. Last Nixon				4. DATE OF DEATH Aug 3 1960 Month Aug Day 3 Year 1960									
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/22/1874		9. AGE (last birthday) 86		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) Boone County, Mo.		12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME Oliver Nixon				13b. MOTHER'S MAIDEN NAME Elizabeth McKee				14. NAME OF HUSBAND OR WIFE Deceased					
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. No		17. INFORMANT Address Mrs. W. A. Thornton Columbia, 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) ARTERIOULAR NEPHROSCLEROSIS WITH OREMA										INTERVAL BETWEEN ONSET AND DEATH 6 mo.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) GENERALIZED ARTERIOULAR NEPHROSCLEROSIS								Year Year			
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROTIC HEART DISEASE										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 Approx. 1957 to Sept. 3, 1960 and last saw him alive on Sept. 3, 1960 Death occurred at 2:15 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) J. H. Hester, M.D.						22b. ADDRESS 329 Main St., Boonville, Mo.				22c. DATE SIGNED 9/5/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9/6/1960		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town, or county) (State) Boone County, Mo.							
24. FUNERAL DIRECTOR Lyman Sprinkle Columbia, Mo.				ADDRESS		25. DATE RECD. BY LOCAL REG. 9/5/60		26. REGISTRAR'S SIGNATURE J. H. Hooper					

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

Lyman Spurdle

Licensed Embalmer No. *4013*

P. O. Address *Columbus*

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.