

# R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-045738

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Registration District No. \_\_\_\_\_ Primary Registration District No. 2000 Registrar's No. 1264-A STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <u>Greene</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Greene</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Length of stay in 1b	c. CITY OR TOWN <u>Springfield</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>Burge Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1425 E. Central</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nick</u> Middle <u>Joney</u> Last <u>Nease</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-1960</u>	9. AGE (last birthday) IF UNDER 1 YEAR Months <u>10</u> Days _____ IF UNDER 24 HR Hours _____ Min. _____	
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>Alabama</u>	12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Paul H. Nease</u>		13b. MOTHER'S MAIDEN NAME <u>Carolyn Sue Bills</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>		
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>none</u>	17. INFORMANT Address <u>Mrs. Imojune Nease, Springfield, 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>Pneumonia.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>inability to swallow safely</u>					10 1/4 months	
DUE TO (c) <u>central nervous system impaired</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>convulsive disorder</u>				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 checked="" 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>12-18-60</u> to <u>12-20-60</u> and last saw <sup>her</sup> <u>him</u> alive on <u>12-20-60</u> Death occurred at <u>10 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>David A. Thomas M.D.</u>			22b. ADDRESS <u>600 S Eleventh</u>		22c. DATE SIGNED <u>12-28-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-20-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>		
24. FUNERAL DIRECTOR <u>Rex Rainey, Springfield, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-30-60</u>		26. REGISTRAR'S SIGNATURE <u>Effie H. Meltan</u>	

(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 *Lee Mann*

Licensed Embalmer No. 456  
P. O. Address *Birmingham*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.