

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048933

FILED VS JAN 23 1961

Registration District No. 381 Primary Registration District No. 4515 Registrar's No. 114

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Sullivan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>			Length of stay in 1b	c. CITY OR TOWN <u>Milan</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>Sullivan Co. Memorial Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alex</u> Middle _____ Last <u>Nothy</u>				4. DATE OF DEATH Month <u>December</u> Day <u>31</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 checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 1887</u>	9. AGE (last birthday) <u>73</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)		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>		11. BIRTHPLACE (City and state or country) <u>Zilah, Hungary</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Nathan Nothy</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT <u>Dr. Anton Nothy</u> Address <u>320 W Merrick Rd. Freemont, New York</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>Hemorrhage in left cerebral hemisphere fracture of left frontal bone &amp; orbital probably due to blow on left side head</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 da.</u> <u>Dec. 24, 1960</u> <u>Dec. 24, 1960</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypertension</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 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.) <u>Was struck on left eye, became unconscious</u>					
20c. TIME OF INJURY <u>noon</u>	Hour <u>_____</u> Month, Day, Year <u>12 24 60</u>	(by one Max Williams, assailant) <u>at once, never regained consciousness</u>					
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.) <u>Riddle station</u>	20f. CITY, TOWN, OR LOCATION <u>Milan</u>		COUNTY <u>Sullivan</u>	STATE <u>Missouri</u>		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <u>1:25</u> a. m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>E. W. Simpson D.O.</u> (Degree or title) <u>Coroner</u>				22b. ADDRESS <u>Milan, Missouri</u>		22c. DATE SIGNED <u>1-3-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal &amp; Burial</u>	23b. DATE <u>1-4-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Valley of Peace</u>		23d. LOCATION (City, town, or county) <u>North 30th St. Quincy Illinois</u>		(State)	
24. FUNERAL DIRECTOR <u>Riggen Funeral Home</u>		ADDRESS <u>Milan, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>1-5-61</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>		

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 Lawrence C. Hagg

Licensed Embalmer No. 379

P. O. Address Waco

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.