

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-010157

AMENDED

Registration District No. 290 Primary Registration District No. \_\_\_\_\_ Registrar's No. 32

STATE FILE NUMBER

FILED APR 7 1961

1. PLACE OF DEATH a. COUNTY <u>Pulaski</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Pulaski</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Waynesville</u>	Length of stay in lb <u>1 Day</u>	c. CITY OR TOWN <u>Richland</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>General Hospital</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>---</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Lilburn</u> Last <u>Nolan</u>			4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 26 1880</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>	11. BIRTHPLACE (City and state or country) <u>Swedeborg Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Nolan</u>		13b. MOTHER'S MAIDEN NAME <u>Georgia Ann Decker</u>		14. NAME OF HUSBAND OR WIFE <u>May Nolan</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. _____		17. INFORMANT Address <u>May Nolan Richland, Missouri</u>	

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>METASTATIC CARCINOMA OF</u>			<u>2 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>LUNG.</u>		
	DUE TO (c) <u>CARCINOMA OF STOMACH</u>		
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 type="checkbox"/> N. <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" 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.) <u>✓</u>	20f. CITY, TOWN, OR LOCATION <u>Richland</u>	COUNTY <u>Missouri</u> STATE _____

21. I attended the deceased from MAY 1950 to MARCH 18, 1961 and last saw <sup>her</sup>him alive on MARCH 12, 1961  
Death occurred at 3:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John A. Mikalevich D.O.</u> (Degree or title)		22b. ADDRESS <u>CROCKER, MO.</u>		22c. DATE SIGNED <u>3-19-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/20/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	23d. LOCATION (City, town, or county) <u>Richland, Missouri</u> (State)	
24. FLORIST'S ADDRESS <u>Moss-Williams Richland Missouri</u>		25. DATE RECD. BY LOCAL REG. <u>3-20-61</u>	26. REGISTRAR'S SIGNATURE <u>Paul J. Anderson</u>	

DATE AMENDED

INSTEAD OF DOCUMENT

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

APR 7 1961

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Clarice Thorse

Licensed Embalmer No. 4891  
4896

P. O. Address Wayne, Mich

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.