

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013567

STATE FILE NUMBER

AMENDED

Registration District No. 141 Primary Registration District No. 555 Registrar's No. 64

FILED MAY 7 1961

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| 1. PLACE OF DEATH a. COUNTY <u>Hawell</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Hawell</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u> | | Length of stay in 1b | c. CITY OR TOWN <u>West Plains</u> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Rt 2</u> |
| | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Albert</u> Last <u>Nalte</u> | | | 4. DATE OF DEATH Month <u>4</u> - Day <u>3</u> - Year <u>61</u> | | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>Wht</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-1-1876</u> | 9. AGE (last birthday) <u>84</u> | IF UNDER 1 YEAR Months <u>8</u> Days <u>22</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (City and state or country) <u>Herman, Mo. U.S.A.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Vincent Nalte</u> | | 13b. MOTHER'S MAIDEN NAME <u>Theresa Kibner</u> | | 14. NAME OF HUSBAND OR WIFE <u>Hella Senger</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 17. INFORMANT <u>Lucille Cable</u> | | Address <u>Rt 2 West Plains</u> | |

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| 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>Congestive heart failure</u> | | <u>6 weeks</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Arteriosclerotic heart disease</u> | <u>3 mo</u> |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Benign Prostatic Hypertrophy</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 |
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| 19. WAS AUTOPSY PERFORMED? YES <input 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.) |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | Month, Day, Year | |

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|--|--|------------------------------|--------|-------|
| 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 3/1/61 to 4/3/61 and last saw him alive on 4-3-61
Death occurred at 3:20 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>M. L. Fowler</u> (Degree or title) | 22b. ADDRESS <u>West Plains, Mo</u> | 22c. DATE SIGNED <u>4/24/61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>4-6-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Hopping Springs Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>West Plains, Mo.</u> |
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| 24. FUNERAL DIRECTOR <u>Robertson West Plains</u> | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>4-26-61</u> | 26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u> |
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Al. P. Sabeyto

Licensed Embalmer No. 3432

P. O. Address _____

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.