

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038754

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9857**

STATE FILE NUMBER

FILED NOV 8 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Length of stay in 1b 53 years		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4512 West Pine Frazier Nursing Home				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4249 Hunt Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE LAST REBECCA NUNNALLY JACK			4. DATE OF DEATH Month Day Year October 22 1961					
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-2-1880	9. AGE (last birthday) 81	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Boonville, Mo. Cooper Co. USA		12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME James P. Nunnally			13b. MOTHER'S MAIDEN NAME Arleinesa (UNKNOWN)			14. NAME OF HUSBAND OR WIFE George Jack		
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. None		17. INFORMANT Address Mrs. Mabel Frazier, 4512 West Pine St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia (Viral)</i> DUE TO (b) DUE TO (c) <i>492 x F</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Fracture of hip (L.H.), chronic debility</i>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>Fell at Nursing Home, fracturing hip.</i>					
20c. TIME OF INJURY Hour a.m. p.m. <i>10-2-1961</i>								
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.) <i>19 4512 West Pine</i>		20f. CITY, TOWN, OR LOCATION St. Louis		COUNTY STATE Mo.		
21. I attended the deceased from <i>June 1961</i> to <i>10-24-61</i> and last saw her/him alive on <i>10-21-61</i> Death occurred at <i>3:45 P.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (D, free or title) <i>M. R. Rindelman M.D.</i>				22b. ADDRESS <i>1005 Bay View St.</i>		22c. DATE SIGNED <i>10-23-61</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE <i>10-25-61</i>	23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.			
24. FUNERAL DIRECTOR ADDRESS <i>Alexander & Sons, 6175 Delmar Blvd.</i>				25. DATE RECD. BY LOCAL REG. <i>10-25-61</i>	26. REGISTRAR'S SIGNATURE <i>John E. Murphy M.D.</i>			

*Dr. K. K. Taylor
Coroner 10-27-61*

Dr. Nathan Kimmelman
1005 Big Bend Blvd.

PHONE: ST 1-3400

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

jos emcullor

Licensed Embalmer No. 2760

P. O. Address 6170 Rm

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.