

# SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-029923  
STATE FILE NUMBER

Registration District No. 3600 Primary Registration District No. 3076 Registrar's No. 197

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<b>FILED NOV 7 1961</b>		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Vernon</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Nevada</u>		c. CITY OR TOWN <u>Kennett</u>	
Length of stay in lb <u>6 Wks</u>		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>#812 N. Washington Tate Nursing Home</u>		d. STREET ADDRESS <u>205 Harvey</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Nichols</u> Last <u>Nichols</u>			4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>61</u>		
5. SEX <u>f</u>	6. COLOR OR RACE <u>W</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>9/11/72</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>		11. BIRTHPLACE (City and state or country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <u>John Dearing</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Vaughn</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) <u>No</u> <input checked="" type="checkbox"/> <u>X</u> <input checked="" type="checkbox"/> <u>X</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs Richardson, Kennett, Mo.</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>Congestive heart failure</u>		DUE TO (b) <u>Coronary arteriosclerosis</u>		<u>36 hrs</u>	
DUE TO (c) <u>General arteriosclerosis</u>				<u>Unknown</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"/> 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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u> / <u>  </u> / <u>  </u>				
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>October 13, 1951</u> to <u>October 28th</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>October 28, 1961</u> Death occurred at <u>5:20 P.M.</u> the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>L.P. McCann</u> (Degree or title)		22b. ADDRESS <u>L.P. McCann, M. D. Moore Bldg. Nevada, Mo.</u>		22c. DATE SIGNED <u>10/30/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/30/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>X</u>		23d. LOCATION (City, town, or county) (State) <u>Kennett Mo.</u>	
24. FUNERAL DIRECTOR <u>McDaniel Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>Nov 1 - 1961</u>		26. REGISTRAR'S SIGNATURE <u>Anna J. Jurey</u>	

**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 *Roy C McLeod*

Licensed Embalmer No. 4853

P. O. Address Florida, MO

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.