

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041600

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 382 Primary Registration District No. 5655 Registrar's No. 114

STATE FILE NUMBER

FILED DEC 6 1961

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u>		c. CITY OR TOWN <u>Wellston</u>	
Length of stay in 1b <u>10 days</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>Mo. State Sanatorium</u>		d. STREET ADDRESS (If outside, give location) <u>6222 Suburban</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <u>Ada</u>	Middle <u>B.</u>	Last <u>McNairy</u>	4. DATE OF DEATH	Month <u>November</u>	Day <u>22</u>	Year <u>1961</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</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>3-18-96</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
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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	11. BIRTHPLACE (City and state or country) <u>Abërdeen, Mississippi</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>
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13a. FATHER'S NAME <u>Arthur Walker</u>	13b. MOTHER'S MAIDEN NAME <u>Charity Walker</u>	14. NAME OF HUSBAND OR WIFE <u>Marcus McNairy</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	17. INFORMANT Address <u>Hospital records, Mo. S. S., Mt. Vernon, Mo.</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: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Arterioneuroclerosis</u> DUE TO (c) <u>Pyelonephritis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
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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>Pulmonary tuberculosis, far advanced, active; Diabetes mellitus.</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 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.)
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20c. TIME OF INJURY Hour, s.m., p.m.	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
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21. I attended the deceased from 11-12-61 to 11-22-61 and last saw her alive on 11-22-61
Death occurred at 9:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>A. Vernon Langelutz, M.D.</u> (Degree or title)	22b. ADDRESS <u>Mo. State Sanatorium, Mt. Vernon, Mo.</u>	22c. DATE SIGNED <u>11-24-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-22-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u> (State)
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24. FUNERAL DIRECTOR <u>Gene Lowe Undertaker Co - St. Louis Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>11-30-61</u>	26. REGISTRAR'S SIGNATURE <u>Ray Wayne</u>
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DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

MEDICAL CERTIFICATION BY AFFIDAVIT OF

MS DEC 6 1961

MAR 13 1962

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 *X* Leroy E. Dennis

Licensed Embalmer No. 4523

P. O. Address 4251 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.