

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009334

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 347 Primary Registration District No. 570 Registrar's No. 690

**FILED** MAR 1 5 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <b>ST. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>AFFTON</b>		c. CITY OR TOWN <b>ST. Louis</b>	
Length of stay in 1b <b>DAYS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Miller Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>5425 CHRISTY BLVD</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>Nesmith</b> Last			4. DATE OF DEATH Month <b>Feb</b> Day <b>24</b> Year <b>1962</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-16-1879</b>
9. AGE (last birthday) <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (City and state or country) <b>Mo.</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13. MOTHER'S MAIDEN NAME	
13a. FATHER'S NAME <b>Edward EHRlich</b>		14. NAME OF HUSBAND OR WIFE <b>August Nesmith (Died)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Nellie Kadlee</b>		Address <b>5425 CHRISTY BLVD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cardio Vascular Disease and</b>			<b>1 yr.</b>
DUE TO (c) <b>Arteriosclerosis 4201</b>			<b>1 yr.</b>
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 checked="" 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 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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>Feb. 13th, 1962</b> to <b>Feb. 24 '62</b> and last saw her/him alive on <b>Feb. 23 1962</b> Death occurred at <b>1 A. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>M. A. Walters M. D.</b>		22b. ADDRESS <b>3608 So. Grand Blvd</b>	22c. DATE SIGNED <b>2/26/62</b>
23. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>Feb 27, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FARBER Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>FARBER No</b>
24. FUNERAL DIRECTOR <b>Thomas Ruto</b>	ADDRESS <b>2906 Shawnee</b>	25. DATE RECD. BY LOCAL REG. <b>2-26-62</b>	26. REGISTRAR'S SIGNATURE <b>James H. Murphy M.D.</b>

Dr. Watson

Mrs. Gladys Bell

PR2-2891

col of 1 pm

**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 *Carley Thompson*

Licensed Embalmer No. 4861

P. O. Address Clayton 5, 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.