

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-039019

5399 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5399

FILED NOV 1 1962

VS 300
Rev. 4/59

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DATE AMENDED
12-3-62

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
3-7-1919 + 34

ITEM NO. SHOULD READ
8+9 3-7-1919 + 43

DOCUMENT double check record
BY AFFIDAVIT OF Informant
GELLEN V. Pflieger MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Jackson City</u>		Length of stay in 1b <u>22 yrs</u>	c. CITY OR TOWN <u>Jackson City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>806 Spruce</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>806 Spruce</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALDENA M VAN NEST</u>			4. DATE OF DEATH Month Day Year <u>October 22 1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>3-9-1919</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>43</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Pittsburg Ken U.S.A.</u>
13a. FATHER'S NAME <u>Floyd E Harrison</u>		13b. MOTHER'S MAIDEN NAME <u>Edna Mae Wisk</u>	14. NAME OF HUSBAND OR WIFE <u>Malvin E Van Nest</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>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Marjorie J Jackson Topeka Ken</u> Address
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>Cardiac arrhythmia, resident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial infarction</u> DUE TO (c) <u>Hypertensive nephropathy</u>			INTERVAL BETWEEN ONSET AND DEATH
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 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 <u>10-9-62</u> to <u>10-19-62</u> and last saw her/him alive on <u>10-19-62</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Edgar D. Bolla</u>		(Degree or title)	22b. ADDRESS <u>3011A 2nd Ave</u>
22c. DATE SIGNED <u>10/22/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Oct 24 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Ken</u>	23d. LOCATION (City, town, or county) <u>Jackson City Mo.</u> (State)
24. FUNERAL DIRECTOR <u>Home K.P. Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-23-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

USE BLACK INK OR TYPEWRITER RIBBON

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 Thomas A. Shiel

Licensed Embalmer No. 4954

P. O. Address HP 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.

STATE BOARD OF HEALTH OF THE DISTRICT OF COLUMBIA