

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042374

STATE FILE NUMBER

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 273

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 19 1962

VS 300
Rev. 4/59

10425

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clinton</u>		Length of stay in 1b <u>5 years</u>	c. CITY OR TOWN <u>Clinton</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>Wetzel Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Harvey</u> Last <u>Nickell</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>13</u> Year <u>1962</u>	
5. SEX <u>Male</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>4/10/01</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>61</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11a. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William A. Nickell</u>		13b. MOTHER'S MAIDEN NAME <u>Emma B. Shumate</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Mrs. Bob Evans, Butler Mo</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>Cerebrovascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes</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
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.)	
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>9-15-67</u> to <u>Nov. 13, 1962</u> and last saw her him alive on <u>Nov 12, 1962</u> Death occurred at <u>1:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R. E. Harbaugh, M.D.</u>		22b. ADDRESS <u>Clinton Mo.</u>	22c. DATE SIGNED <u>11-14-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/15/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Walnut Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Paris Mo</u>
24. FUNERAL DIRECTOR <u>Graciel Geneva Home Care</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>Nov 14, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Waldred Bigman</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 *F B Goodrich*

Licensed Embalmer No. 3038

P. O. Address *Peoria Ill*

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.

Permit Obtained

11/14/62

M.B.