

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044672

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11243** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| a. COUNTY ST. LOUIS MO | | a. STATE MO b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO | | c. CITY OR TOWN ST. LOUIS | |
| Length of stay in lb 29 YEARS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3501 CONNECTICUT | | d. STREET ADDRESS (If outside, give location) 3501 CONNECTICUT | |
| 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 Middle Last BESSE NASHUARD | | | 4. DATE OF DEATH Month Day Year 11-22-62 |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8-17-1894 |
| 9. AGE (last birthday) 68 | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE & SECRETARY | | 10b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL CO. | 11. BIRTHPLACE (City and state or country) BEATTIE, KANS. |
| 12. CITIZEN OF WHAT COUNTRY U.S.A. | | 13a. FATHER'S NAME JOSEPH H. THORN | |
| 13b. MOTHER'S MAIDEN NAME IDA MARTIN | | 14. NAME OF HUSBAND OR WIFE ELMER NASHUARD | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO | | 16. SOCIAL SECURITY NO. 208 ELMER NASHUARD 3501 CONNECTICUT | |
| 17. INFORMANT Address 3501 CONNECTICUT | | 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: | |
| IMMEDIATE CAUSE (a) CARCINOMA OF COLLEBLADDER, WITH LIVER METAS. | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 1551 | | DUE TO (c) | |
| 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 Aug 25, 1962 to NOV 22, 1962 and last saw her alive on NOV 22, 1962 . Death occurred at 10:35 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Paul W. Larson M.D. (Degree or title) | | 22b. ADDRESS 3654 South Grand | |
| 22c. DATE SIGNED 11/23/62 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 11-26-1962 | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEMETERY | 23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MO. |
| 24. FUNERAL DIRECTOR ADDRESS HOWARD H. MICHEL 5930 SOUTHWEST | | 25. DATE RECD. BY LOCAL REG. NOV 23 1962 | |
| | | 26. REGISTRAR'S SIGNATURE Paul Smith, M.D. | |

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

Gustav W. Schuler

Licensed Embalmer No. 14329

P. O. Address

St Louis 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.