

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045712

STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 4533 Registrar's No. 16

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED DEC 10 1962</b>								
<p><b>1. PLACE OF DEATH</b></p> <p>a. COUNTY <b>Warren</b></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marthasville</b> Length of stay in 1b <b>10 months</b></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>None</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p><b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <b>Missouri</b> b. COUNTY <b>Warren</b></p> <p>c. CITY OR TOWN <b>Marthasville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <b>None</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>							
<p><b>3. NAME OF DECEASED</b> First Middle Last <b>Alex William Nissing</b></p>								
<p><b>4. DATE OF DEATH</b> Month Day Year <b>November 30, 1962</b></p>								
<p><b>5. SEX</b> <b>Male</b></p>	<p><b>6. COLOR OR RACE</b> <b>White</b></p>	<p><b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>10/4/1889</b></p>	<p><b>9. AGE (last birthday)</b> <b>73</b></p>	<p><b>IF UNDER 1 YEAR</b> Months Days Hours Min.</p>	<p><b>IF UNDER 24 HR</b> Hours Min.</p>		
<p><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b></p>		<p><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Grain Farm</b></p>		<p><b>11. BIRTHPLACE</b> (City and state or country) <b>Marthasville, Mo.</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY</b> <b>U. S. A.</b></p>		
<p><b>13a. FATHER'S NAME</b> <b>John Nissing</b></p>			<p><b>13b. MOTHER'S MAIDEN NAME</b> <b>Dorothea Gade</b></p>			<p><b>14. NAME OF HUSBAND OR WIFE</b> <b>Clara Nissing</b></p>		
<p><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b></p>			<p><b>16. SOCIAL SECURITY NO.</b></p>			<p><b>17. INFORMANT</b> Address <b>Mrs. Clara Nissing, Marthasville, Mo.</b></p>		
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:</p>						<p>INTERVAL BETWEEN ONSET AND DEATH</p>		
<p>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b></p>						<p><b>1 day</b></p>		
<p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)</p>						<p><b>3 year</b></p>		
<p>DUE TO (b) <b>Carcinoma of Prostate</b></p>								
<p>DUE TO (c)</p>								
<p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)</p>						<p><b>PART III. If deceased was female was there a pregnancy in last 90 days.</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>		
<p><b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/></p>		<p><b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/></p>		<p><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)</p>				
<p><b>20c. TIME OF INJURY</b> Hour a.m. p.m.</p>		<p>Month, Day, Year</p>						
<p><b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/></p>		<p><b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>20f. CITY, TOWN, OR LOCATION</b></p>		<p>COUNTY STATE</p>		
<p><b>21. I attended the deceased from</b> <b>12/5/62</b> to <b>April 30/62</b> and last saw him alive on <b>Nov 29/62</b></p> <p>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.</p>								
<p><b>22a. SIGNATURE</b> <i>H.C. Johnson M.D.</i> (Degree or title)</p>				<p><b>22b. ADDRESS</b> <b>Marthasville Mo.</b></p>		<p><b>22c. DATE SIGNED</b> <b>12/3/62</b> (State)</p>		
<p><b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b></p>		<p><b>23b. DATE</b> <b>12/3/1962</b></p>		<p><b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Paul's Cemetery</b></p>		<p><b>23d. LOCATION</b> (City, town, or county) <b>Marthasville, Missouri</b></p>		
<p><b>24. FUNERAL DIRECTOR</b> <b>D. F. Lichtenberg</b> ADDRESS <b>Marthasville, Mo.</b></p>				<p><b>25. DATE RECD. BY LOCAL REG.</b> <b>12/3/1962</b></p>		<p><b>26. REGISTRAR'S SIGNATURE</b> <i>H.C. Johnson</i></p>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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JAN 18 1963

**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 Hermon F. Zuberkey

Licensed Embalmer No. 4318

P. O. Address Marthasville, 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.