

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

83-043247

STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 141

FILED DEC 11 1963

1. PLACE OF DEATH a. COUNTY <u>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u>		Length of stay in 1b <u>8 days</u>	c. CITY OR TOWN <u>Lawson</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>220 Bluff St,</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>409 E.5th</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Maud</u> Last <u>Nolker</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1963</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>5-19-1884</u>	9. AGE (last birthday) <u>79</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keeping house</u>		11. BIRTHPLACE (City and state or country) <u>Concord, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Henry W. Hill</u>		13b. MOTHER'S MAIDEN NAME <u>Ella Blair</u>	
14. NAME OF HUSBAND OR WIFE <u>William N. Nolker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO. [Redacted]	
17. INFORMANT <u>Katherine E. Fleming,</u>		Address <u>220 Bluff St.</u>		<u>Excelsior Spg.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u>					INTERVAL BETWEEN ONSET AND DEATH <u>hour</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Thrombotic Encephalomalacia</u>					<u>day</u>
DUE TO (c) <u>Chronic Arteriosclerosis</u>					<u>year</u>
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 <u>5-20-57</u> to <u>11-25-63</u> and last saw her/him alive on <u>11-25-63</u> Death occurred at <u>1:00 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>C.F. Lambert</u> (Degree or title)			22b. ADDRESS <u>main & Suttle St</u> <u>Excelsior Springs, Mo</u>		22c. DATE SIGNED <u>11-27-63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-27-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		23d. LOCATION (City, town, or county) (State) <u>Lawson, Missouri</u>
24. FUNERAL DIRECTOR <u>Jarman Funeral Home, Lawson, Mo</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>11-25-63</u>	26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	

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AMENDED

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

MEDICAL CERTIFICATION

DOCUMENT

Removal Permit Serial 11-27-63 E.H.

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 Lindell Jarman

Licensed Embalmer No. 4589
P. O. Address Excelsior Springs, 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.