

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12135-63-049805
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 ST. 32365 Primary Registration District No. 1003 XC-9195896 Registrar's No.

FILED DEC 20 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	SHOULD READ	ITEM NO.
Rev. 4/59								
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1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		c. CITY OR TOWN	
		St. Louis, Missouri		3 Years		Missouri	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION				Inside Limits		d. STREET ADDRESS (If outside, give location)	
VA Hospital, St. Louis				Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		903 Aubert, Apt. 126	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. MONTH DAY YEAR	
First		Middle		Last			
WILLIE		NASH				12-6-63	
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HR
Male	Negro		11-25-10	53	Months	Days	Hours
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)		12. CITIZEN OF WHAT COUNTRY	
Laborer				Meridian, Miss		U.S.A.	
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE	
Louis Nash			Emma Leonard				
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.		17. INFORMANT Address		
Yes					Mitchell Nash (Brother) See #2		
18. CAUSE OF DEATH (Enter only one cause per line)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)				Hypoglycemia of Unknown Etiology			
DUE TO (b)				Acute Brain Syndrome of Unknown Etiology			
DUE TO (c)				Miliary Tuberculosis incl lungs, Far Advanced			
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 checked="" type="checkbox"/> NO <input 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.)			
				0021			
20c. TIME OF INJURY		Hour a.m. p.m.		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>11-6-63</u> to <u>12-6-63</u> and last saw him alive on <u>12-6-63</u>							
Death occurred at <u>10:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Do not write in title)				22b. ADDRESS		22c. DATE SIGNED	
<i>John J. Funkhouser</i>				VAH, ST. LOUIS, MISSOURI		12-6-63	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Removal		12-12-63		National Cemetery		Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR ADDRESS				25. DATE RECD. BY LOCAL REG.		REGISTRAR'S SIGNATURE	
A. L. Beal Und. Co. 4303 Delmar				DEC 9 1963		<i>Roan Smith, M.D.</i>	

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 Vera Thompson Nelson

Licensed Embalmer No. 4435

P. O. Address 4303 Pearlman

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.