

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-021102

FILED JUL 7 1959

Registration District No. 137 Primary Registration District No. 3023 Registrar's No. 163

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Henry</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Henry</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Clinton MO</u>		Length of stay in 1b <u>10 days</u>		c. CITY OR TOWN <u>Urich MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) <u>Joseph General Hospital</u>				Inside Limits 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>Joseph</u> Middle <u>Nesson</u> Last <u>Nesson</u>				4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>7-2-1878</u>	
9. AGE (last birthday) <u>81</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (City and state or country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>							
13a. FATHER'S NAME <u>William Nesson</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Caldwell</u>			14. NAME OF HUSBAND OR WIFE <u>W. J. Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>W. J. Brown</u>	
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>Cerebral Vascular Accident</u> DUE TO (b) <u>Arteriosclerotic vascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 years</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 type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input 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.)			
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 <u>Urich</u>		COUNTY <u>MO</u> STATE _____	
21. I attended the deceased from <u>Nov. 1958</u> to <u>June 30 1959</u> and last saw him alive on <u>June 6, 1959</u> Death occurred at <u>3:00 P</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>A. M. McIntyre M.D.</u>				22b. ADDRESS <u>Clinton MO.</u>		22c. DATE SIGNED <u>6-30-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-2-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>White Oak Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Urich MO.</u>	
24. FUNERAL DIRECTOR <u>Brown & Graham</u>				ADDRESS <u>Urich MO</u>		25. DATE RECD. BY LOCAL REG. <u>7-1-59</u>	
				26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R R Kenney

Licensed Embalmer No. 3099
P. O. Address Clinton 9

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.