

FILED

JAN 8 1946 STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 50

Primary Registration District No. 3010

Registrar's No. 400

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days
In this community 7 1/2 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scott
(c) City or town Chaffee Mo
(If outside city or town limits, write "RURAL.")
(d) Street No. R. 7 D #1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Jacqueline Mae Nardin

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased: April 14 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months 7 Days 20 If less than one day hr. _____ min. _____

9. Birthplace Cape Girardeau Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER { 12. Name Jessie H. Nardin
13. Birthplace Chaffee Mo
(City, town, or county) (State or foreign country)
14. Maiden name Marion Clark
15. Birthplace Chaffee Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Marion Nardin
(b) Address Chaffee Mo

17. (a) Burial (b) Date thereof 12-5-1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Bur. Cem.

18. (a) Signature of funeral director Unstable - Chaffee Mo

(b) Address Chaffee Mo

19. (a) 12-6-1945 (b) C.F. Business
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4
year 1945 hour 6 minute _____ a. M.

21. I hereby certify that I attended the deceased from Dec 1
1945 to Dec 4, 1945;
that I last saw her alive on Dec 4 1945, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Resp Infection 4 Days
Due to Storvlon Enteritis 2 Wks

Due to Anemia Secondary

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy 119W

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? No (Specify type of place) (e) Means of injury _____

23. Signature W.C. Jones (M. D. or other) 12/4/45
Address Chaffee Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

Health Officer No. 4
File Number 146-1479
Filed 1-7-46

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.....

working under my personal supervision.

Registered Apprentice No.....

Not Embalmed

Signed *St. Paul Funeral Home, Mitchell*

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.