

FILED NOV 25 1946

State File No. \_\_\_\_\_  
Registrar's No. 51470

Registration District No. 149 Primary Registration District No. 1001

1. PLACE OF DEATH:  
 (a) County Jackson  
 (b) City or town JC Mo  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St Marys Hosp.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 day 8 hrs 35 min  
 (Specify whether, years, months or days)  
 In this community 1 day 8 hrs 35 min

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo (b) County Jackson  
 (c) City or town JC  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 132 N. Lawrence  
 (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Michael Le Roy Nail  
 (b) If veteran, name war no (c) Social Security No. none

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month 11 day 12  
 year 1946 hour 8 minute 55 P.M.  
 21. I hereby certify that I attended the deceased from 11  
11 1946 to 11-12 1946  
 that I last saw him alive on 11-12 1946  
 and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W  
 6. (a) Single, widowed, married, divorced single  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death: Atelectasis of Lungs Prematurity  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) 159

7. Birth date of deceased: 11-11-1946  
 (Month) (Day) (Year)

Major findings: See above  
 1 of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

8. AGE: Years \_\_\_\_\_ Months 1 Days 8 If less than one day hr. 35 min.

9. Birthplace: JC Mo  
 (City, town, or county) (State or foreign country)

10. Usual occupation: new-born

11. Industry or business: \_\_\_\_\_  
 12. Name: Belle Gene Nail  
 13. Birthplace: Albany Missouri  
 (City, town, or county) (State or foreign country)

14. Maiden name: Elizabeth Marie Burdick  
 15. Birthplace: Highmore S Dak  
 (City, town, or county) (State or foreign country)

16. (a) Informant: father  
 (b) Address: 132 N. Lawrence

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov-13-1946  
 (Month) (Day) (Year)  
 (c) Place: burial or cremation: Grant City Mo

18. (a) Signature of funeral director: Mr C L Foster  
 (b) Address: 918 Broadway  
 19. (a) 11-13-46 (Date received local registrar) (b) Almaidine Holmes (Registrar's signature)

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? 13  
 While at work? \_\_\_\_\_ (Specify type of place)  
 Method of injury: \_\_\_\_\_  
 23. Signature: A. E. Wosher M.D. (M. D. or other)  
 Address: 2800 Main Date: 11/13/46

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

35931  
 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....

*Not Embalmed*....., Registered Apprentice No.....,  
working under my personal supervision.

Signed.....

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.**