

FILED JAN 12 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3462

BIRTH NO. _____ REG. DIST. NO. 322 PRIMARY REG. DIST. NO. 3071 Registrar's No. 60

1. PLACE OF DEATH a. COUNTY <i>Saline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY <i>Saline</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Slater</i>		c. LENGTH OF STAY (in this place) <i>4 days</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Jarvis Convalescent</i>		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Slater</i>	
f. STREET ADDRESS (If rural, give location) <i>431 North Walnut St</i>		3. NAME OF DECEASED a. (First) <i>NANNIE BELLE</i> b. (Middle) <i>STROUD</i> c. (Last) _____	
4. DATE OF DEATH (Month) (Day) (Year) <i>January 6 1951</i>		5. SEX <i>Female</i>	
6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	
8. DATE OF BIRTH <i>Sept 28-1868</i>		9. AGE (in years) (last birthday) (Months) (Days) (Hours) (Min.) <i>82-3-8</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Give if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>work</i>	
11. BIRTHPLACE (State or foreign country) <i>Near Slater, Saline Co, Mo</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>George W. Johnson</i>		13b. MOTHER'S MAIDEN NAME <i>Marie Kirby</i>	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <i>M. L. Stroud</i> ADDRESS <i>Slater, Mo</i>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Coronary Thrombosis. W.D. disease</i> ANTECEDENT CAUSES DUE TO (b) <i>Bronchial Asthma</i> DUE TO (c) <i>Acute Infarction</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>None</i>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>None</i>	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>None</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>None</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE ON TRIP <input type="checkbox"/> AT HOME <input type="checkbox"/> <i>None</i>	
21f. HOW DID INJURY OCCUR? <i>None</i>		22. I hereby certify that I attended the deceased from <i>Jan 1</i> , 1951, to <i>Jan 2</i> , 1951, that I last saw the deceased alive on <i>Jan 2</i> , 1951, and that death occurred at <i>8:17</i> m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <i>M. L. Stroud</i>		23b. ADDRESS <i>Slater, Mo</i>	
23c. DATE SIGNED <i>Jan 1 1951</i>		24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
24b. DATE <i>1-8-51</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Slater City Cemetery</i>	
24d. LOCATION (City, town, or county) (State) <i>Slater, Mo</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Jones & Salzer</i> ADDRESS <i>Slater, Mo</i>	
DATE REC'D BY LOCAL REG. <i>1-9-51</i>		REGISTRAR'S SIGNATURE <i>Ms. Earl C. Metzger</i>	

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

RECEIVED 1-11-51

DISTRICT HEALTH OFFICE No. 3

District File Number

Date Filed 1-11-51

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
Student Embalmer

Signed *James E. Jones*

Licensed Embalmer No. *3143*

P. O. Address *Statesville, N.C.*

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.