

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27537

FILED SEP 12 1952

BIRTH NO. _____ REG. DIST. NO. 77 PRIMARY REG. DIST. NO. 3016 Registrar's No. 221

2640

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

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Jefferson City</u>		c. LENGTH OF STAY (in this place) <u>15 yrs.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Marys Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>California St. off Hough Park Rd.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Robert F.</u> b. (Middle) <u>Nald</u> c. (Last) <u>Nald</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 2-1952</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>April 13, 1886</u>
9. AGE (In years last birthday) <u>66</u>		UNDER 1 YEAR <u>4</u> Months	10. UNDER 1 M. <u>23</u> Hours
10a. USUAL OCCUPATION (This kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber Shop</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Rock Island, Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Unknown</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>329-05-2728</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Virginia Nald</u>		ADDRESS <u>Havana, Cuba.</u>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>			?
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u>			?
DUE TO (c) <u>Essential Hypertension</u>			?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma prostate.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X H</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 4, 1952</u> , to <u>Sept 6, 1952</u> that I last saw the deceased alive on <u>Sept 6, 1952</u> , and that death occurred at <u>4:20 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Carl L. D. Loyd M.D.</u>		23b. ADDRESS <u>Jeff. City, Mo.</u>	
23c. DATE SIGNED <u>9/7/52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Normal</u>		24b. DATE <u>Sept 8 1952</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Chippinok</u>		24d. LOCATION (City, town, or county) (State) <u>Rock Island, Ill.</u>	
DATE REC'D BY LOCAL REG. <u>Sept 7-1952</u>		REGISTRAR'S SIGNATURE <u>R. P. Darrin M.D. - MR.</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>James Hume - J. C. Mo.</u>		ADDRESS	

FORM 8 1961

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 _____

Licensed Embalmer No. 3641

P. O. Address Genoa.

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.