

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 2 1954

State File No. **3092**
0635

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Tennessee b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jackson		
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Pacific Hospital		d. STREET ADDRESS (If rural, give location) 606 Day Street		
3. NAME OF DECEASED (Type or Print) a. (First) MOSE		b. (Middle)		c. (Last) NIXON
4. DATE OF DEATH (Month) (Day) (Year) JAN. 20 1954		4. DATE OF DEATH (Month) (Day) (Year)		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH May 1, 1890	9. AGE (In years last birthday) 63 If under 1 year: Months 8 Days 19 If under 12 mos. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper	10b. KIND OF BUSINESS OR INDUSTRY G M & O R.R.	11. BIRTHPLACE (City and State or Foreign Country) Unknown, Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Tommie Nixon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --		17. INFORMANT'S SIGNATURE OR NAME Tommie Nixon, 606 Day St., Jackson
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation Tenn. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Latent Diabetes		
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)		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200B
22. I hereby certify that I attended the deceased from JAN. 7 , 19 54 , to JAN. 20 , 19 54 , that I last saw the deceased alive on JAN. 20 , 19 54 , and that death occurred at 8:30 A.m. , from the causes and on the date stated above.				
23. SIGNATURE (Typed or printed name) Charles J. Gates, M.D.		23b. ADDRESS 1755 S. Howard		23c. DATE SIGNED 1-20-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1/22/54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Jackson, Tennessee
DATE REC'D BY LOCAL REG. JAN 21 1954		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates, 4107 Finney Ave

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

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 Arthur L. Hellard

Licensed Embalmer No. 4221

P. O. Address 4524 Alden

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.