

No. 300  
10-48

FILED AUG 20 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 26253

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 53 PRIMARY REG. DIST. NO. 3009 Registrar's No. 381

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

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Cape Girardeau   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY Cape Gir. |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN Jackson, CITY |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN Jackson   |  |
| c. LENGTH OF STAY (in this place) 3 weeks   |  | d. STREET ADDRESS (If rural, give location)<br>610 Old Cape Road  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Deal Nursing Home                                     |  |   |  |

|  |                           |   |  |   |  |   |  |
|--|---------------------------|---|--|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) Linda  |                           | b. (Middle) Agnus   |  | c. (Last) Niblack                                     |  | 4. DATE OF DEATH (Month) (Day) (Year)<br>Aug. 9, 1956 |  |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Widow |  | 8. DATE OF BIRTH<br>Sept. 4, 1887                     |  | 9. AGE (In years last birthday) 68                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Nursing |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Deal Nursing Home          |  | 11. BIRTHPLACE (State or foreign country)<br>Missouri |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                |  |

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 13a. FATHER'S NAME<br>Henry Koechig  |  | 13b. MOTHER'S MAIDEN NAME<br>Wilhelmina Brunke |  | 14. NAME OF HUSBAND OR WIFE<br>Roy W. Niblack        |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service)<br>No |  | 16. SOCIAL SECURITY NO.<br>499-32-2514         |  | 17. INFORMANT'S SIGNATURE OR NAME<br>Paul W. Niblack |  |
|  |  |  |  | ADDRESS<br>Jackson, Mo.                              |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage   |  | INTERVAL BETWEEN ONSET AND DEATH<br>3 days |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Hypertension and arteriosclerosis, 4 yrs |  |  |
|   | DUE TO (c)   |  |  |
| II. OTHER SIGNIFICANT CONDITIONS -<br>Conditions contributing to the death but not related to the disease or condition causing death.   |  |  |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION                          |  | 19b. MAJOR FINDINGS OF OPERATION   |  | 20. AUTOPSY?<br>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)<br>331X                             |  |
| 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 Nov, 1955 to Aug 9, 1956, that I last saw the deceased alive on Aug 8, 1956, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

|                                  |  |                             |  |                                  |  |
|----------------------------------|--|-----------------------------|--|----------------------------------|--|
| 23a. SIGNATURE<br>N. Jaeger M.D. |  | 23b. ADDRESS<br>Jackson, Mo |  | 23c. DATE SIGNED<br>Aug 11, 1956 |  |
|----------------------------------|--|-----------------------------|--|----------------------------------|--|

|   |  |                            |  |   |  |  |  |
|---|--|----------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial |  | 24b. DATE<br>Aug. 11, 1956 |  | 24c. NAME OF CEMETERY OR CREMATORY<br>Russell-Heights |  | 24d. LOCATION (City, town, or county) (State)<br>Jackson Mo. |  |
|---|--|----------------------------|--|---|--|--|--|

|                                     |  |                                       |  |   |  |                         |  |
|-------------------------------------|--|---------------------------------------|--|---|--|-------------------------|--|
| DATE REC'D BY LOCAL REG.<br>8-15-56 |  | REGISTRAR'S SIGNATURE<br>C. C. Sumner |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br>H. L. ... |  | ADDRESS<br>Jackson, Mo. |  |
|-------------------------------------|--|---------------------------------------|--|---|--|-------------------------|--|

(Licensed Embalmer's Statement on Reverse Side)

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 A C Craeft

Licensed Embalmer No. 4327

P. O. Address Jackson, Mo.

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.