

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26415

State File No. 22
Registrar's No. 22

FILED AUG 20 1956

BIRTH NO. _____ REG. DIST. NO. 88 PRIMARY REG. DIST. NO. 5326

1. PLACE OF DEATH a. COUNTY Crawford		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Nebraska b. COUNTY Douglas	
b. CITY OR TOWN Cuba Rural "Nebraska"	c. LENGTH OF STAY (In this place) 2 WKS	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Omaha	
d. FULL NAME OF HOSPITAL OR INSTITUTION At Daughters Home		d. STREET ADDRESS (If rural, give location) 5385 53rd AVE	

3. NAME OF DECEASED (Type or Print) a. (First) Pauline b. (Middle) Marie c. (Last) NELSON	4. DATE OF DEATH (Month) (Day) (Year) 8-14-1956
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 3-27-1872	9. AGE (In years last birthday) 84	10. UNDER 1 YEAR 4	11. UNDER 24 HRS. 17
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Fall City Nebraska	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Charles FALSKO	13b. MOTHER'S MAIDEN NAME MINNA Bahr	14. NAME OF HUSBAND OR WIFE William C. Deed
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME: Mrs Ethel Lindberg Cuba, Mo	ADDRESS
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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) Coronary Heart Disease		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS 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? 4201 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **8-14, 1956**, to **8-14, 1956**, that I last saw the deceased alive on **POA, 1956** and that death occurred at **10:00 am.**, from the causes and on the date stated above.

23a. SIGNATURE J. R. Skelton (Degree or title) D.O.	23b. ADDRESS Cuba Mo.	23c. DATE SIGNED 8-14-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-17-56	24c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	24d. LOCATION (City, town, or county) (State) Lawrence Kansas
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DATE REC'D BY LOCAL REG. 8/18/56	REGISTRAR'S SIGNATURE Mrs Hazel Lichner	25. FUNERAL DIRECTOR'S SIGNATURE Norman Coffman ADDRESS Cuba, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 18 1958

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 Norman C. Hoener

Licensed Embalmer No. 4673

P. O. Address Quila, 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.