

Health,  
Welfare  
Public  
Service

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34803

STATE FILE NUMBER

FILED NOV 12 1957

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 402

1. PLACE OF DEATH a. COUNTY <u>DOONE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>Newton</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Neosho</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ug Mo Medical Center</u>		Length of stay in lb <u>23 days</u>	d. STREET ADDRESS (If outside, give location) <u>Route 3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>ELIZA</u> Last <u>Caldwell</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-99</u>	9. AGE (In years last birthday) <u>58</u> IF UNDER 1 YEAR: Months <u>07</u> Days <u>28</u> IF UNDER 24 HRS.: Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>McDonald County Mo</u>	
13. FATHER'S NAME <u>Charles Nance</u>			14. MOTHER'S MAIDEN NAME <u>MARY Arnold</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>5501</u>		17. INFORMANT <u>U of Mo Medical Center Records, Columbia, Mo</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>entero-cutaneous fistula</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Peri-cecal abscess</u> DUE TO (c) <u>appendicitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>none</u> <u>6 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>6:40</u> Month, Day, Year <u>11/3/57</u> a. m. <u>00</u> p. m. <u>00</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>10/11/57</u> to <u>11/3/57</u> and last saw <u>her</u> alive on <u>11/3/57</u> Death occurred at <u>6:40</u> <u>am</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Nellie M. Wade, M.D.</u>			22b. ADDRESS <u>506 Keller Columbia Mo</u>		22c. DATE SIGNED <u>11/3/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>11-4-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Neosho</u>	
23d. LOCATION (City, town, or county) <u>Mo.</u>		24. FUNERAL DIRECTOR <u>Parker Funeral Service, Columbia, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 4 1957</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>					

(Licensed Embalmer's Statement on Reverse Side)

NOV 20 1957

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 .....  
Signature of Student Embalmer

Signed *Henry G. Vannum* .....

Licensed Embalmer No. *44*

P. O. Address *Calamba*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.