

Health,  
& Welfare  
Public  
Service

S. 300  
7. 1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 20 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 10714

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 474

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Levasy		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Independence Hosp.			Length of stay in 1b 2 days		d. STREET ADDRESS none		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Deanne Lyn Nowack				4. DATE OF DEATH Month Day Year Nov. 7, 1957			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1957		9. AGE (In years last birthday) 2 days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY XXXXXXX		11. BIRTHPLACE (City and state or country) Independence, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Glenn A. Nowack				14. MOTHER'S MAIDEN NAME Shirley M. Winkelhake			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		(If yes, give war or dates of service) XXXX		16. SOCIAL SECURITY NO. XXX		17. INFORMANT Glenn A. Nowack, Levasy, Mo.	
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>Hyaline Membrane Disease of lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							INTERVAL BETWEEN ONSET AND DEATH 2 days
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.) 5272 _____				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____				
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION _____		COUNTY STATE		
21. I attended the deceased from <u>Nov-5-1957</u> to <u>Nov 7, 1957</u> and last saw her alive on <u>Nov-7-1957</u> Death occurred at <u>2:00 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>James W. [Signature]</u>				22b. ADDRESS <u>110 Oak Grove, Mo</u>		22c. DATE SIGNED <u>11/9/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Nov. 9, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Levasy Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Levasy, Missouri</u>	
24. FUNERAL DIRECTOR <u>Hazel H. Reppert</u>			ADDRESS <u>Buckner, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-9-57</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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NOV 18 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 *Ralph Jones*  
Licensed Embalmer No. *460*  
P. O. Address *Odessa*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.