

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024363

STATE FILE NUMBER

Health,  
Welfare  
Public  
Service

300  
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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FULFILL JUL 1 1958 Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 126			
1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Vernon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Nevada</b>		c. CITY OR TOWN <b>Nevada</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Nevada City Hospital</b> Length of stay in 1b <b>12hrs</b>		d. STREET ADDRESS <b>515 So. Main</b> (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>Catherine</b> Last <b>Cocke</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1880</b>
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (City and state or county) <b>Near Blue Mound, Kan.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>W. N. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Hutiburg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>R. J. Cocke</b>		Address <b>515 S. Main Nevada, Mo.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Hypertension</b>			<b>15 years</b>
DUE TO (c) <b>Hypertensive cardiovascular disease</b>			<b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <b>4201</b>	
20c. TIME OF INJURY Hour _____ 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 <b>June 18, 1958</b> to <b>June 20, 1958</b> and last saw her <del>alive</del> <b>alive</b> on <b>June 20, 1958</b> Death occurred at <b>Nevada, Mo.</b> <b>9:30 Pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>I. P. McCann, M.D.</b>		22b. ADDRESS <b>Moore Bldg., Nevada, Mo.</b>	
22c. DATE SIGNED <b>6-21-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/24/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Plesant Grove Cemetery</b>	
		23d. LOCATION (City, town, or county) (State) <b>St. Clair County--Mo.</b>	
24. FUNERAL DIRECTOR <b>Eichinger Funeral Home</b>		ADDRESS <b>*Nevada, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>6-28-1958</b>		26. REGISTRAR'S SIGNATURE <b>Anna E. Ferry</b>	

(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.....  
Signature of Student Embalmer

Signed *Sally F. Webster*.....

Licensed Embalmer No. *480*.....

P. O. Address *Nevada*.....

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.