

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016435
STATE FILE NUMBER

FILED MAY 7 1959 Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 78

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-57

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY New Madrid	
b. CITY OR TOWN Sikeston		c. CITY OR TOWN Lilbourn	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Delta Comm. Hosp.		d. STREET ADDRESS (If outside, give location) —	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First	Middle	Last	Month	Day	Year
EULA	ELIZABETH	NANCE	4	10	1959

5. SEX F. male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-1928	9. AGE (In years last birthday) 31	10. FUNDER 1 YEAR	11. IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Julin, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Walter Nance	13b. MOTHER'S MAIDEN NAME Mary Crut	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT Effie Nance-Lilbourn, Mo.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETIC COMA		INTERVAL BETWEEN ONSET AND DEATH 18 HRS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) DIABETES MELLITUS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260X		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.)
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20c. TIME OF INJURY Hour 9 AM a.m. p.m.	Month, Day, Year 4.10.59
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION Sikeston, Mo.	COUNTY	STATE
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21. I attended the deceased from Death occurred at 5:55 P.	and last saw her alive on 4.10.59
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22a. SIGNATURE Carl G. Poppe M.D.	(Degree or title)	22b. ADDRESS Sikeston, Mo.	22c. DATE SIGNED 4.11.59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4-12-59	23c. NAME OF CEMETERY OR CREMATORY Matthews Cem.	23d. LOCATION (City, town, or county) Matthews, Mo.	(State)
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24. FUNERAL DIRECTOR Alberton Funeral Home	ADDRESS Sikeston, Mo.	25. DATE RECD. BY LOCAL REG. 4-27-59	26. REGISTRAR'S SIGNATURE Mrs. Eula Nance
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

(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 *Raymond L. Duffe*
Licensed Embalmer No. *4728*
P. O. Address *Bernie No*

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.