

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-001196

STATE FILE NUMBER

FILED VS. JAN 11 1960 / 28

Primary Registration District No. \_\_\_\_\_

Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <b>Greene</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Walnut Grove</b>		Length of stay in 1b <b>many years</b>		c. CITY OR TOWN <b>Walnut Grove</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3 mi East of W. G.</b>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dora</b> Middle <b>Margaret</b> Last <b>Nail</b>				4. DATE OF DEATH Month <b>January</b> Day <b>1</b> Year <b>1960</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>May 13, 1877</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR 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 country) <b>Summerset Kentucky</b>		12. CITIZEN OF WHAT COUNTRY <b>US A</b>
13a. FATHER'S NAME <b>Allen Gilliland</b>			13b. MOTHER'S MAIDEN NAME <b>Nancy Bryan</b>			14. NAME OF HUSBAND OR WIFE <b>Jake Nail</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 Address <b>Mo.</b> <b>Lola Harman Walnut Grove</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>RESPIRATORY FAILURE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 hr.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>PULMONARY EDEMA</b>						<b>1 wk</b>	
DUE TO (c) <b>CONGESTIVE HEART FAILURE</b>						<b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____					
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 <b>JAN 1, 1955</b> to <b>JAN 1 1960</b> and last saw her <sup>her</sup> <sub>big</sub> alive on <b>Dec 31 1959</b> Death occurred at <b>8:30 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Deed to or title) <b>W. R. Davis D.O.</b>				22b. ADDRESS <b>Walnut Grove Mo.</b>		22c. DATE SIGNED <b>1/4/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
<b>Burial</b>	<b>1/3/60</b>	<b>Greenlawn Cemetery</b>		<b>Walnut Grove, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Brim-Daniel-Walnut Grove-Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>Jan 6, 1960</b>		26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond L. Sawyer

Licensed Embalmer No. 42

P. O. Address Ashe Gap

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to conform 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.