

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044860

FILED VS NOV 28 1960

STATE FILE NUMBER

Registration District No. 340 Primary Registration District No. 6152 Registrar's No. 98

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dunklin</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dexter Liberty Twp</u>		Length of stay in lb <u>2</u> Months		c. CITY OR TOWN <u>Kennett</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Green Meadows Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Harriett</u> Middle <u>Elizabeth</u> Last <u>Nail</u>				4. DATE OF DEATH Month <u>November</u> Day <u>6</u> , Year <u>1960</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-15-1885</u>		9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></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>-----</u>		11. BIRTHPLACE (City and state or country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Andy Owens</u>				13b. MOTHER'S MAIDEN NAME <u>Josie Shelby</u>				14. NAME OF HUSBAND OR WIFE <u>W.S. Nail (Deced)</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Louie Nail R#1 Holcomb, 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>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cardiac Failure</u> DUE TO (c) <u>Cerebral Thrombosis</u> 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 <u>18 hr.</u> <u>10 days</u> <u>3 mo.</u>			
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 <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></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>Nov. 1, 1960</u> to <u>Nov. 6, 1960</u> and last saw her alive on <u>Nov. 5, 1960</u> Death occurred at <u>6:45</u> <u>7</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Degree or title)						22b. ADDRESS <u>Dexter, Mo.</u>			22c. DATE SIGNED <u>11-15-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>8 Nov. 60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Gardens</u>			23d. LOCATION (City, town, or county) (State) <u>Kennett, Missouri</u>					
24. FUNERAL DIRECTOR <u>McDankel Funeral Ser. Kennett, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>11-17-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

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 Tommy L. Schertz

Licensed Embalmer No. 4886

P. O. Address Kennerly

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.