

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-004574

STATE FILE NUMBER

AMENDED

Registration District No. **38** Primary Registration District No. **3006** Registrar's No. **130**

FILED VS MAR 6 1961

1. PLACE OF DEATH a. COUNTY BOONE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Sheeps									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Columbia Mo.		Length of stay in lb 20 DAYS		c. CITY OR TOWN ST. JAMES		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION U. Medical Center			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 900 FLOKINE		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First James Middle Roy Last Nilges				4. DATE OF DEATH Month Feb Day 26 Year 61									
5. SEX Male		6. COLOR OR RACE Cauc		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 11-21-98		9. AGE (last birthday) 62		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) factory worker				10b. KIND OF BUSINESS OR INDUSTRY International Shoe Mfg. Co. Mo.				11. BIRTHPLACE (City and state or country) U. S. A.		12. CITIZEN OF WHAT COUNTRY			
13a. FATHER'S NAME Benjamin Nilges				13b. MOTHER'S MAIDEN NAME Laronia Sweaney				14. NAME OF HUSBAND OR WIFE Mrs. Lillie Nilges					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) was no world war				16. SOCIAL SECURITY NO.				17. INFORMANT U. Medical Records - Columbia Mo.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Congestive Heart Failure										1 year			
DUE TO (b) Calcific Aortic Stenosis										?			
DUE TO (c)													
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 type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Feb 23 61 , to Feb 26 and last saw her alive on Feb 26 1961 Death occurred at 12:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) C. Thayer Roy M.D.						22b. ADDRESS Columbia, Mo				22c. DATE SIGNED 2/26/61			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)		STATE			
Burial		March 1-61		Reburied Cemetery				J E Mo					
24. FUNERAL DIRECTOR Tanner Sutter						25. DATE RECD. BY LOCAL REG. Feb 27-61		26. REGISTRAR'S SIGNATURE Mrs. R.E. Palmer					

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

VS MAR 22 1961

MAR 8 1961

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.