

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041522
STATE FILE NUMBER

MENT OF PUBLIC HEALTH AND WELFARE
Registration District No. 162 Primary Registration District No. 5595 Registrar's No. 121

AMENDED FILED DEC 8 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JEFFERSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN IMPERIAL		Length of stay in 1b	c. CITY OR TOWN IMPERIAL
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R.R.#2		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R.R.#2
3. NAME OF DECEASED (Type or print) First ROY Middle NILES Last		4. DATE OF DEATH Month DEC. Day 3 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11, 1994
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, or if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY GARAGE	9. AGE (last birthday) 67
11. BIRTH-PLACE (City and state or country) MEXICO MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME FRED NILES		13b. MOTHER'S MAIDEN NAME MARY ROBERTS	
14. NAME OF HUSBAND OR WIFE ALICE NILES		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bariumnitric Cyanuric			INTERVAL BETWEEN ONSET AND DEATH 6 months
DUE TO (b) 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 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 <u>9/6/61</u> to <u>12/13/61</u> and last saw him alive on <u>12/13/61</u> Death occurred at <u>5:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Charles Burnside MD (Degree or title)		22b. ADDRESS 206 W. Argonne Highway	22c. DATE SIGNED 12/5/61
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE DEC. 6, 1961	23c. NAME OF CEMETERY OR CREMATORY MT. HOPE CEM.	23d. LOCATION (City, town, or county) (State) LEMAY MO.
24. FUNERAL DIRECTOR THOMAS KUTIS ADDRESS 2906 GRAVOIS		25. DATE RECD. BY LOCAL REG. 12-6-1961	26. REGISTRAR'S SIGNATURE Robert E. Bauer

DEC 28 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 Samuel E. White

Licensed Embalmer No. 4347

P. O. Address 2906 Davis

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.