

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-046000

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 498

AMENDED

FILED DEC 29 1961

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| 1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Francois</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u> | | Length of stay in 1b <u>10 days.</u> | c. CITY OR TOWN <u>(Mitchell)</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>Bonne Terre Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Elvins R1, Mo.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Larry</u> Middle <u>Bernard</u> Last <u>Nolan</u> | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>19,</u> Year <u>1961</u> | | |
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| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-21-1961</u> | 9. AGE (last birthday) <u>21</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | 11. BIRTHPLACE (City and state or country) <u>Bonne Terre, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Oran Nolan</u> | 13b. MOTHER'S MAIDEN NAME <u>Golda Mathes</u> | 14. NAME OF HUSBAND OR WIFE <u>None</u> |
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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) <u>No</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>Oran Nolan, Elvins R1, Mo.</u> | Address <u> </u> |
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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: | | INTERVAL BETWEEN ONSET AND DEATH <u>12 days.</u> |
| IMMEDIATE CAUSE (a) <u>labor pneumonia</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u> </u> | |
| | DUE TO (c) <u> </u> | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Cerebral retardation - congenital</u> | | 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 |
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| 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.) <u> </u> |
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| 20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> | Month <u> </u> Day <u> </u> Year <u> </u> |
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| 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.) <u> </u> | 20f. CITY, TOWN, OR LOCATION <u> </u> | COUNTY <u> </u> | STATE <u> </u> |
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21. I attended the deceased from Dec 7, 1961 to Dec 19, 1961 and last saw him alive on Dec 18, '61
Death occurred at 3 AM on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>J. L. Foster MD</u> (Degree or title) | 22b. ADDRESS <u>Desloge Mo</u> | 22c. DATE SIGNED <u>12-20-61</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12-21-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Farmington (St. Francois) Mo</u> |
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| 24. FUNERAL DIRECTOR <u>Bert L. Boyer, Leadwood, Mo.</u> | ADDRESS <u> </u> | 25. DATE RECD. BY LOCAL REG. <u>Dec. 20, 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Eather Rudloff</u> |
|---|----------------------|--|--|

DATE AMENDED

INSTEAD OF

SHOULD READ

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Beard L. Boyer

Licensed Embalmer No. 3541

P. O. Address Spokane, Idaho

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.