

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-003920

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **184** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 16 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		c. CITY OR TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
		ST. LOUIS, MISSOURI		23 days		PA.		St. Clair		E. St. Louis					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS		(If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		BARNES HOSPITAL		1207 Tudor			
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH			
Fannie			NMN			Nicholson			1			6 63			
5. SEX		6. COLOR OR RACE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HR			
Female		Negro				3-4-404		58		Months 10		Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY			
Housewife				At home				Scottsbl, Miss				USA			
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
Simon Beckst				Carrie Nicholson				William							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address			
No								William Nicholson				1207 Tudor			
18. CAUSE OF DEATH (Enter only one cause per line)												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:												10 da.			
IMMEDIATE CAUSE (a)												ANURIA SECONDARY TO INVOLVEMENT OF KIDNEY			
DUE TO (b)												SYSTEMIC SCLERODERMA			
DUE TO (c)												710.0			
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		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		12/14/62		to		1/6/63		and last saw her alive on		1/6/63		Death occurred at			
		11:30 a.m.		m		on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title)						22b. ADDRESS						22c. DATE SIGNED			
C. Demillion, M.D.						BARNES HOSPITAL						1/6/63			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county)				(State)			
Removal		1-7-63		Sunset Garden of Memory				Centerville, Missouri							
24. FUNERAL DIRECTOR				ADDRESS				25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE					
Nash Funeral Home				1117 1/2 E. Eldred				JAN 7 1963		Roald Smith, M.D.					

DATE AMENDED
28/20/7
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

VS 300
Rev. 4/59
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3
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1
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1252-0
52
USE BLACK INK OR TYPEWRITER RIBBON

STATE OF ILLINOIS

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 Mr. James Wash

Licensed Embalmer No. 4434

P. O. Address 1117 13th - East St. Louis

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.