

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-010003

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 321 Primary Registration District No. 30720 Registrar's No. 33

FILED FEB 25 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Length of stay in 1b <b>27 years</b>	c. CITY OR TOWN <b>Marshall</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzgibbon Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>758 So. Brunswick</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>WINSTON KELLER NIX</b>			4. DATE OF DEATH Month Day Year <b>February 16, 1963</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-28-1906</b>
9. AGE (last birthday) <b>56</b>		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) <b>Medical Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>	11. BIRTHPLACE (City and state or country) <b>Butler, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>William J. Nix</b>	
13b. MOTHER'S MAIDEN NAME <b>Madge Keller</b>		14. NAME OF HUSBAND OR WIFE <b>Jane Hawkins Nix</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. W. K. Nix, Marshall, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Collapse</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>undetermined cause (Laboratory procedure not yet completed)</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 <b>4/15/63</b> to <b>2/11/63</b> and last saw him alive on <b>2/16/63</b> Death occurred at <b>9:20am</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Howin E. Rothen</i> (Degree or title)		22b. ADDRESS <i>4400 1/2 mo</i>	22c. DATE SIGNED <b>2/17/63</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-18-1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	23d. LOCATION (City, town, or county) <b>Butler, Missouri</b>
24. FUNERAL DIRECTOR <b>Campbell-Lewis Marshall, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>2-17-63</b>	26. REGISTRAR'S SIGNATURE <i>Carl G. Read</i>

MAR 19 1963

**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 James H. Lewis Jr.

Licensed Embalmer No. 4709

P. O. Address Marshall, Mo.

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.