

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-015466

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 43

Primary Registration District No. \_\_\_\_\_

Registrar's No. 63-27

STATE FILE NUMBER

**FILED APR 18 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Dade</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>                           |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Lockwood Mo.</u>  |  | Length of stay in 1b<br><u>3 wks</u>  | c. CITY OR TOWN <u>Greenfield Mo.</u><br>Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>   |  | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><u>Commercial Hotel</u><br>Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>       |
| 3. NAME OF DECEASED<br>(Type or print) First <u>Rice</u> Middle <u>Nance</u> Last <u>Nance</u>  |  |   | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>2</u> Year <u>1963</u>   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 24 1881</u>   |
| 9. AGE (last birthday) <u>81</u>  |  | IF UNDER 1 YEAR<br>Months <u>8</u> Days <u>8</u>  | IF UNDER 24 HR<br>Hours <u>8</u> Min. <u></u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Miller</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Milling</u>   | 11. BIRTHPLACE (City and state or country)<br><u>Kansas City Kans.</u>   |
| 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |  | 13a. FATHER'S NAME <u>John D Nance</u>  |  |
| 13b. MOTHER'S MAIDEN NAME <u>Narcissis Nance</u>  |  | 14. NAME OF HUSBAND OR WIFE<br><u>Lenora Nance</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>[redacted]</u>   | 17. INFORMANT<br>Name <u>Noble Jones</u> Address <u>So Greenfield Mo.</u>  |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____<br>DUE TO (c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Pulmonary Tuberculosis, arrested</u>  |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/>   | 20b. SUICIDE <input type="checkbox"/>   | 20c. 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<br>Hour _____ a.m. _____ p.m.   | Month, Day, Year _____   |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>NOT WHILE AT WORK <input checked="" 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>3/20/63</u> to <u>4/2/63</u> and last saw him alive on <u>4/2/63</u><br>Death occurred at <u>7:45 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.   |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Lee A. McNeely MD</u>  |  | 22b. ADDRESS<br><u>Greenfield Mo</u>  | 22c. DATE SIGNED<br><u>4/6/63</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE<br><u>April 7 1963</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Antioch</u>  | 23d. LOCATION (City, town, or county) (State)<br><u>Dade Co Mo</u>   |
| 24. FUNERAL DIRECTOR<br><u>Allison Funeral Home Greenfield Mo</u>   |  | 25. DATE RECD. BY LOCAL REG.<br><u>4/10/1963</u>  | 26. REGISTRAR'S SIGNATURE<br><u>J. C. Canada</u>   |

USE BLACK INK

OR TYPEWRITER RIBBON

Lee A. McNeely, Jr., M.D.

**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 W.R. Allison

Licensed Embalmer No. 4404  
P. O. Address Sumfield, 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.