

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

66 0042478

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 393

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 31 1966

1. PLACE OF DEATH a. 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 _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>523 N. Jackson</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u> c. CITY OR TOWN <u>Bonne Terre</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (if outside, give location) <u>523 N. Jackson</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 Middle Last <u>Clarence Joseph Nash</u>			4. DATE OF DEATH Month Day Year <u>Oct. 13, 1966</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/1913</u>	9. AGE (last birthday) <u>53</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. Joseph Lead</u>		11. BIRTHPLACE (City and state or country) <u>Blackwell, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	

13a. FATHER'S NAME <u>Joseph Nash</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Caine</u>	14. NAME OF HUSBAND OR WIFE <u>Leona Webb Nash</u>
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>523</u>
17. INFORMANT <u>Mrs. Leona Nash - Bonne Terre, Mo.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several year</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
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) <u>Pulmonary emphysema</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.)		
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from March 1958 to 9-8-66 and last saw him alive on 9-8-66
 Death occurred at 2:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) 	22b. ADDRESS <u>Bonne Terre, Missouri</u>	22c. DATE SIGNED <u>10-22-66</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francois Mem. Park</u>	23d. LOCATION (City, town, or county) (State) <u>Bonne Terre, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>C.Z. Boyer & Son - Bonne Terre, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 24, 1966</u>	26. REGISTRAR'S SIGNATURE
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
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 2 0941
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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

Burial Permit issued ^{DEC 7 1956} 02 24-66

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 Basilio T. Bayon

Licensed Embalmer No. 5117

P. O. Address Bonifacio

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.