

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

67 0002455

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 382 Primary Registration District No. 5655 Registrar's No. 952 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 18 1967

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 a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Crawford	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon		Length of stay in 1b 30 days	c. CITY OR TOWN Cuba
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri State Sanatorium		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 type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hattie Middle Frances Last Nixon			4. DATE OF DEATH Month Jan. Day 14, Year 1967
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/21/1888
9. AGE (last birthday) 78		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) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sligo, Missouri
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Hiram Usery	
13b. MOTHER'S MAIDEN NAME Lucy Mallow		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 487-32-6756	17. INFORMANT Hospital record, Mo. State San.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus			INTERVAL BETWEEN ONSET AND DEATH few hours
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) Pulmonary Tuberculosis, active Diabetes Mellitus			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 Dec. 15, 1966 to Jan. 14, 1967 and last saw her ^{her} alive on Jan. 14, 1967 Death occurred at 1:00 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Willie S. Cortez M.D.</i>		22b. ADDRESS Mo. State Sanatorium, Mt. Vernon	22c. DATE SIGNED 1/14/67
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-14-67	23c. NAME OF CEMETERY OR CREMATORY Shoal Creek Cemetery	23d. LOCATION (City, town, or county) (State) Crawford Co. Mo.
24. FUNERAL DIRECTOR Halbert Funeral Home		ADDRESS Steelville Mo.	25. DATE RECD. BY LOCAL REG. 1-16-67
			26. REGISTRAR'S SIGNATURE <i>Roy Shanthana</i>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK OR TYPEWRITER RIBBON

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

Max L. Ferrell

Licensed Embalmer, No.

4252

P.O. Address

Wabasha, 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.