WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Daviess Co

Township Grand River Registration District No. 257 File No. 7989

or Village _____ Primary Registration District No. 5350 Registered No. _____

or City _____ (NO. _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Alice Nichols

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Jan. (Month) 15 (Day), 1875 (Year)

AGE: 29 yrs. _____ mos. 24 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer): — 23

BIRTHPLACE (City or town, State or foreign country): Daviess Co

PARENTS

NAME OF FATHER: Siegel Nichols

BIRTHPLACE OF FATHER (City or town, State or foreign country): Indiana

MAIDEN NAME OF MOTHER: Phorba Nichols

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Daviess Co

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno Musselman

(ADDRESS) Gallatin Mo

Filed Mar. 20, 1914. N. M. Wetzel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Feb (Month) 10 (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from May, 1913, to Feb 10, 1914, that I last saw her alive on Feb 10, 1914, and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Stomach & Intestines

(Duration) _____ yrs. 6 mos. _____ ds.

Contributory (SECONDARY) Pulmonary T. B.

(Duration) 2 yrs. _____ mos. _____ ds.

(Signed) McKinley & Harris M. D.

Feb 10, 1914 (Address) Jamesport Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Prairie Valley

DATE OF BURIAL: Feb 12, 1914

UNDERTAKER: A. H. Pettijohn

ADDRESS: Gallatin Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. .... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... , *1*.....
(Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ..... , 191..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... , *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ..... , 191..... , to ..... , 191..... , that I last saw h..... alive on ..... , 191..... , and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs. .....mos. .....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs. .....mos. .....ds.

(Signed)..... M. D.

..... , 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... , 191.....
UNDERTAKER	ADDRESS