PLACE OF DEATH

County Oregon

Township Piney

Village

Registration District No. 634

Primary Registration District No. 5844

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

File No. 36883

Registered No.

(NO. St.; Ward)

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

FULL NAME William Henry Nickless

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: November 8, 1890 (Month) (Day) (Year)

AGE: 29 yrs. — mos. 26 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): General Farming

BIRTHPLACE (City or town, State or foreign country): Leon Kansas

NAME OF FATHER: Alonzo Nickless

BIRTHPLACE OF FATHER (City or town, State or foreign country): Bedford Ind.

MAIDEN NAME OF MOTHER: Iris S. Nickless

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Donica Tunnelton Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alonzo Nickless.

(ADDRESS) Alton R. F.D. #1

Filed Jan 10. 1920. Emrich Bailey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH December 5, 1919 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 16, 1919, to Dec. 5, 1919, that I last saw him alive on Nov. 4, 1919, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) 1 yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) R. E. Eblen M. D.

Jan 10 1920 (Address) Alton 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: Cave Spring cemetery

DATE OF BURIAL: December 6. 1919

UNDERTAKER: D. R. Johnson

ADDRESS: Couch Mo

PLACE OF DEATH

County _____

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

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurr
hospital or inst
give its NAME
of street and num

FULL NAME _____

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

_____, 19
(Month) (Day)

I HEREBY CERTIFY, that I attended deceased

_____, 191____, to _____, 19

that I last saw h_____ alive on _____, 191

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____ M.

_____, 191____ (Address) _____

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

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

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

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