LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH
County: Dallas
Township: Wilson
or
Village:
or
City: (NO. , St.; Ward)

Registration District No. 247 File No. 15971
Primary Registration District No. 5343 Registered No. 6

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

2 FULL NAME: Frank Charles Nixon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: white
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: Feb (Month) 10 (Day), 1920 (Year)

7 AGE: yrs. 2 mos. 12 ds.
If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Mo

PARENTS
10 NAME OF FATHER: Paul Nixon
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
12 MAIDEN NAME OF MOTHER: Pearl Cash
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): M. J. Wheeler
(Address): Buffalo Mo

15 Filed 4/22, 1920 J. Ballot Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 22 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from april 21, 1920, to april 21st, 1920, that I last saw him alive on apr 21, 1920, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis
24A (Duration) yrs. mos. 4 ds.

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

(Signed) J. Ballot M. D.
4/21, 1920 (Address) Long Lane Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Hall Grave Yard
DATE OF BURIAL: 4/23, 1920
UNDERTAKER: Newport Supply
ADDRESS: Buffalo

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

1 PLACE 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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

7 AGE ..... yrs. ..... mos. ..... ds.

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

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 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.

18 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 .....

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

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.

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