

NOV 22 1930

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

Do not use this space.

29485

1. PLACE OF DEATH

County Dade Registration District No. 237
Township Center Primary Registration District No. 5323
City Greenfield (No. 7124) St. _____ Ward _____

File No. _____
Registered No. 37

2. FULL NAME

James E. Nail
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male White married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Ella M. Nail

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 13 - 1890

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
59 9 0

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dade Co Mo

10. NAME OF FATHER Wm. Nail

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) W. Va

12. MAIDEN NAME OF MOTHER Martha Brentner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Dade Co

14. INFORMANT Mrs Jas Nail
(Address)

15. FILED 9-16-30 E. O. Ball REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-15-1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Sept 15, 1930, that I last saw him alive on Sept 15, 1930, and that death occurred, on the date stated above, at 10:20 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Liver involving Gall Bladder
46E
(duration) yrs. 15 mos. ds.

CONTRIBUTORY (SECONDARY) 44B
(duration) yrs. _____ mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. at place of death

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Pseudor Allen Ponce, M. D.

, 19 (Address) Greenfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Pleasant Grove Cem. 9-16 1930

20. UNDERTAKER ADDRESS
J. A. Ward Greenfield Mo.

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.

