

MISSOURI JAN 1 2 1939

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

41671
Do not use this space.
4737

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 395
 (b) Township Rain Primary Registration District No. 100
 (c) City Keokuk (d) Street No. 3015 Prospect St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Cordie Elizabeth Nickell
 (a) Residence, No. 3015 Prospect St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Wid
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John A Nickell
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar-11-1855
 7. AGE YEARS 83 MONTHS 8 DAYS 27 If LESS than 1 day, hrs. or min.
 OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
 FATHER
 13. NAME Joseph Nevins
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky
 MOTHER
 15. MAIDEN NAME Elizabeth Good
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
 17. INFORMANT (ADDRESS) Mrs Nora Witt
3010 Prospect
 18. BURIAL, CREMATION, OR REMOVAL PLACE Greentown DATE Dec 31 1938
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Mrs C F Foster
Keokuk
 20. FILED Dec 5 1938 M. D. Crowe
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-3-38
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
 I last saw _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 2:00 P.M.
 The principal cause of death and related causes of importance were as follows:
Cerebral sclerosis
Encephalomalacia
Terminal bronchopneumonia
 Other contributory causes of importance:
Old healed pulmonary tuberculosis
 Name of operation Autopsy Date of _____
 What test confirmed diagnosis _____ Was there an autopsy Yes
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? Yes
 If so, specify _____
 (Signed) Victor B. Butler, M. D.
 (Address) Law Dept, K.C. Mo.

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.

8719-

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

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.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION FURNISHED
HEREON FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY PAGE

1. PLACE OF DEATH

County Jackson
Township K.C.
City K.C. (No. Ward)

Registration District No. 399
Primary Registration District No. 1002

File No. 41671
Registered No. 4737-

2. FULL NAME

Cordeie G. Nickell

(a) Residence, No. 3015 Prospect St., Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min. 82 8 5

8. Trade, profession, or particular kind of work done, as sewer, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 175 38 Dr. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 3, 1918

22. I HEREBY CERTIFY, That I attended deceased from 19....., to..... 19.....
Last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Cerebral sclerosis
(arterio sclerosis)
encephalomalacia
Broncho Pneumonia
Old healed Pol. T. B.

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury..... 19.....
Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease of injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Victor B. Buhler, M. D.
(Address)

