

REC'D FEB 27 1939

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

3655
Do not use this space.

PLACE OF DEATH
(a) County Ripley Registration District No. 750
(b) Township Douglas Primary Registration District No. 4451 Registered No. _____
(c) City Douglas (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred 38 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds. _____
2. PRINT FULL NAME Littleton Collier Mrs. Nabb
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Unusual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Brown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-6-1850
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 88 7 1
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. Retired
10. Date deceased last worked at this occupation (month and year) 1915
11. Total time (years) spent in this occupation _____
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Centerville Missouri
13. NAME Mrs. Nabb
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennissie
15. MAIDEN NAME unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee
17. INFORMANT (ADDRESS) J. W. Mc Nabb, Bernier Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Cal Ridge Cem DATE 1-9-39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jordan Adolphson Edouard
20. FILED 1-17-39 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7-39, 1939
22. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1939, to Jan 7, 1939. I last saw him alive on Jan 6, 1939. Death is said to have occurred on the date stated above, at 9:00 p.m.
The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage
Date of onset _____
Other contributory causes of importance: Nephritis
Name of operation None Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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? _____
If so, specify _____
(Signed) Dr. R. G. Groce, M. D.
(Address) Bernier Mo

9221

STATEMENT TO THE PUBLIC BY THE BOARD OF EXAMINERS
OF THE STATE OF TEXAS
REGULATING THE PRACTICE OF EMBALMING

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 _____
J. H. Jordan

Licensed Embalmer No. 3200

P. O. Address Doughan

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

365-44
Do not use this space.

PLACE OF DEATH

(a) County Ripley

Registration District No. 75-0

(b) Township Deminghan

Primary Registration District No. 45-1

Registered No. _____

(c) City _____

(d) Street No. _____
(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

Littleton Collier Mc Nab

(a) Residence, No. _____ St.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

m

4. COLOR OR RACE

w

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

m

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. or _____ min.

88

7

1

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.

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

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1-17-39

E. B. Johnston
Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7-39

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I 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 Hemorrhage
13!
nephritis - Chronic

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) R. J. Groves, M. D.

(Address) Berne, Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PROVIDED BY LAW.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important.

SUPPLEMENTARY

