

NOV 24 1939

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

37504

Do not use this space.

1. PLACE OF DEATH *Hebster Co 2*
 (a) County..... *Hebster* Registration District No..... *898*
 (b) Township..... *Cent. Wallow* Primary Registration District No..... *6204*
 or
 (c) City..... (d) Street No..... 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.
252
2. PRINT FULL NAME *Elto A. McNick*
 (a) Residence, No..... 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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*
- 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 25 - 1938*
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 0 8
- 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) *Mo O*
- FATHER
 13. NAME *Wm McNick*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Perm O*
- MOTHER
 15. MAIDEN NAME *Rosie Cantrell*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*
17. INFORMANT (ADDRESS) *Wm McNick*
Wiggins, Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE *Century* DATE *Sept 2 1939*
19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Wm McNick*
Wiggins, Mo
20. FILED *10-15 1939* *Lester W. Good*
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept. 1 1939*
22. I HEREBY CERTIFY, That I attended deceased from *Aug 30 1939* to *Aug 31 1939*
 I last saw him alive on *Aug 31 1939*. Death is said to have occurred on the date stated above, at *4:30 P.M.*
 The principal cause of death and related causes of importance were as follows:
Amebic dysentery
 Date of onset *8-15-39*
- Other contributory causes of importance: *128 W*
- 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) *Howard J. Mason, M.D.*
 (Address) *Fardland, Mo.*

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

RECEIVED

District Health Officer No. 6,

District File Number 1139-2195

Date Filed NOV 7 1939

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.