

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.

DEC 15 1939

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

39598
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 316
 (b) Township _____ Primary Registration District No. 2001
 (c) City SPRINGFIELD (d) Street No. 1331 N. Clay Registered No. 817
 (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. 1331 N. Clay 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 7, 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
✓ 78 7 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Rob. Carpenter
 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) Clark County, Mo.

FATHER 13. NAME Wilson Nickelson
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Margaret ?
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Mrs. Mildred Viggers 1331 N. Clay City

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Table Rock Mo. Nov 11 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Atma Fahmayer Springfield Mo.

20. FILE NO. Nov 11 1939 Chestnut St. Local Registry

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 10 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-15-39 to 11-10-39

I last saw him alive on 11-9-39 at 2:41 P.M. Death is said to have occurred on the date stated above, at 2:41 P.M.

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

Coronary Heart disease Date of onset
Chronic
97 W

Other contributory causes of importance: Arteriosclerosis

Name of operation Clinical Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No

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 None (Signed) Henry F. Keubh, M. D.

(Address) 450 W. E. Court

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.

X 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.