

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

7509  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County New Madrid Registration District No. 55  
 (b) Township Anderson Primary Registration District No. 6262  
 (c) City Dixon or (d) Street No. \_\_\_\_\_ St.  
 (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.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME ALBERT NICHOLS  
 (a) Residence, No. Sideon new Rural (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 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 20-1866  
 7. AGE YEARS 73 MONTHS 6 DAYS 10 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. day laborer  
 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) Do not know  
 FATHER  
 13. NAME Do not know  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 MOTHER  
 15. MAIDEN NAME Do not know  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 17. INFORMANT (ADDRESS) Johnnie wife Sideon Mo  
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Stephens Cem DATE 1-31 1946  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Watkins Hwy Service Dexter Mo  
 20. FILED Jan 31 1946 M. V. Munnica Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-30-40 1940  
 22. I HEREBY CERTIFY, That I attended deceased from 1-18-40, 19\_\_\_\_, to 1-18-40, 19\_\_\_\_.  
 I last saw him alive on 1-18-40, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 5 A.M.  
 The principal cause of death and related causes of importance were as follows:  
myocardial failure  
 Other contributory causes of importance: senility  
 Date of onset \_\_\_\_\_  
 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) J. H. Jenkins, M. D.  
 (Address) Sideon, Mo

MARGIN RESERVED FOR BINDING  
 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.  
 V. S. NO. 2 20M-9-19-38 I X16603

RECEIVED

District Health Officer No. 2, ●

District File Number 240-618

Date Filed 2/26/40

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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.



