

MOI 100-1-2 1940

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

8430
Do not use this space.

1. PLACE OF DEATH

(a) County Texas Registration District No. 1032
(b) Township Pierce Primary Registration District No. 6144
(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. How long in U.S. if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS 55 MONTHS 3 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.
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. _____
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) Missouri
13. NAME George Washington Nicholas
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
15. MAIDEN NAME Sarah Josephine Jameson
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
17. INFORMANT (ADDRESS) Weth Warden
18. BURIAL, CREMATION, OR REMOVAL PLACE Winston DATE July 16 40
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Erwin Lantz
Willow Springs
20. FILED Mar 7 1940 Paul R. Curran Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15 1940
22. I HEREBY CERTIFY That I attended deceased from Jan 2 1940 to July 15 1940
last saw him alive on July 12 1940 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:
Cancer of Stomach
Date of onset _____
Other contributory causes of importance: Hb
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) Havah _____ M. D.
(Address) Willow Springs Mo.

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.

0110-1577-011

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 8430

Registration District No. 10.32

Primary Registration District No. 6144

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Iowa
(b) City or town Freese rural
(If outside the city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME

Geo. Freeman Nickol

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16
year 1940 hour _____ minute _____ M.

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

Immediate cause of death _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased: November 8 1885
(Month) (Day) (Year)

Due to _____

8. AGE: Years 55 Months 3 Days 7 If less than one day _____ min.

Due to _____

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

Other conditions: _____ (Include pregnancy within 3 months of death)

10. Usual occupation _____

Major findings: _____ Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

22. If death was due to external causes, fill in the following:

16. (a) Informant _____

(a) Accident, suicide, or homicide (specify) _____

(b) Address _____

(b) Date of occurrence _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(c) Place: burial or cremation _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

(b) Address _____

23. Signature C. T. Cavalier (M. D. or other) _____

19. (a) April 22, 1940 (b) Paul R. Evans
(Date received local registrar) (Registrar's signature)

Address Willow Springs Mo. signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

