

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **14550**

Registration District No. **134**

Primary Registration District No. **5186**

Registrar's No. **7**

1. PLACE OF DEATH:

(a) County **CATTOLE**
 (b) City or town **BOSWORTH MO Rural**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **2 Ridge**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **Life** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Carroll**
 (c) City or town **Rural**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **0**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **DOTA ANN NEHL 400**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **ALVEN NEHL** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Oct 3 1868**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 6 16 hr. min.

9. Birthplace **MISSOURI** (City, town, or county) (State or foreign country)

10. Usual occupation **Business Manager**

11. Industry or business **Farming**

12. Name **NOAH HUNTZINGER**

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

14. Maiden name **MARY E WELEHORN**

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

16. (a) Informant **LOUIS NEHL**

(b) Address **BOSWORTH MO**

17. (a) **Burial** (b) Date thereof **4 23 1940**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MARCELINE MO**

18. (a) Signature of funeral director **David J. Edwards**

(b) Address **Bosworth mo**

19. (a) **4-22-1940** (b) **Mrs. A. G. Brown**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **21**
 year **1940** hour **4.5** minute **P.M.**

21. I hereby certify that I attended the deceased from **May 1 1899** to **April 21 1940**
 that I last saw her alive on **April 21 1940**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma** Duration **1 year**

Due to _____

Due to _____

Other conditions **Anemia**
 (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) **✓**

(b) Date of occurrence **✓**

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

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

12th (Specify type of place) While at work? (e) Measles of injury

23. Signature **W. B. Brown** (M. D. or other)

Address **Bosworth, Mo** Date signed **Apr 23**

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

ms

RECEIVED

District Health Officer No. 8
District File Number
Date Filed 5/11/40

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 _____

working under my personal supervision. _____, Registered Apprentice No. _____

Signed David J. Edward
Licensed Embalmer No. 3265
P. O. Address Roworth M

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. 14550

Registration District No. 134

Primary Registration District No. 2186

Registrar's No. 7

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

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Ridge, Mo
(If outside 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 _____
years, months or days)

3. (a) PRINT FULL NAME

Nora Ann Nell

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 71 Months 6 Days 16 If less than one day _____ hr _____ min

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

10. Usual occupation _____

11. Industry or business _____

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)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 21
year 1940 hour _____ minute _____ M.

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

Immediate cause of death Carcinoma

Duration _____
Died located in ascending colon, probably
Died of gall bladder cancer
Primary colon -
Other conditions Carcinoma
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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

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

(b) Date of occurrence _____

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

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

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

23. Signature A. J. Boesman (M. D. or other) _____

Address Baswell, Mo Date signed _____

SUPPLEMENTAL

S-14550