

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 3960BPrimary Registration District No. 912Registrar's No. 18

1. PLACE OF DEATH:

- (a) County Rail - Jasper Twp
 (b) City or town Rural
 (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

CARL H NUTT 30th

3. (b) If veteran, name war _____

3. (c) Social Security No. None4. Sex Male 5. Color of hair White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____ years

7. Birth date of deceased Jan 27 1915
(Month) (Day) (Year)8. AGE: Years 25 Months 4 Days 5 If less than one day _____ hr. _____ min.9. Birthplace Illinois
(City, town, or county) (State or foreign country)10. Usual occupation farmer

11. Industry or business _____

12. Name George F Nutt13. Birthplace Illinois
(City, town, or county) (State or foreign country)14. Maiden name Elizabeth Nutt15. Birthplace Illinois
(City, town, or county) (State or foreign country)16. (a) Informant Elizabeth Nutt(b) Address Wendover, Mo.17. (a) Funeral (b) Date thereof June 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Union Chapel18. (a) Signature of funeral director W. W. Swaders(b) Address Wendover, Mo.19. (a) June 4 1940 (b) Carrie P. Utterback
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 27
year 1940 hour 12 minute 5. P. M.21. I hereby certify that I attended the deceased from Feb. 21,
_____, 1940, to June 2, 1940
that I last saw him alive on May 18 1940
and that death occurred on the date and hour stated above.

Immediate cause of death

Carcinoma
Stomach & Liver ✓Due to unknownDue to unknownOther conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations Cancer - Stomach and Liver Feb. 1940Of autopsy none

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? 25
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature C. H. Barker (M. D. or other) P. O.Address Center, Mo. Date signed 6-2-40

46

RECEIVED

District Health Cert. No. 10

District File Number 7-40-1399

Date Filed JUL 10 1940

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 W B Waters
Licensed Embalmer No. 3325
P. O. Address Van Dote

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **22601**
Registrar's No. **18**

Registration District No. **912**

Primary Registration District No. **2960**

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

1. PLACE OF DEATH:

(a) County **Palls**
(b) City or town **Sanper T.P.**
(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 _____
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Carl H. Nutt

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, divorced, or married **s**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years **25** Months **4** Days **5** If less than one day _____ h. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(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 **June** day **2** 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 _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Cancer of stomach and liver**
Due to **primary site according to post. symptoms were the stomach.**

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

Major findings: Of operations _____

Of autopsy _____

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

23. Signature **C. H. Brooker** (M. D. or other) _____
Address **Carters** _____ Date signed _____

SUPPLEMENTAL

