

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.

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

22715
Do not use this space.

1. PLACE OF DEATH
(a) County St. Francois Registration District No. 773
(b) Township _____ Primary Registration District No. 4464 Registered No. 123
(c) City Farmington, Mo. (d) Street No. _____
(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. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mr. Traug Catherine Nicholson
(a) Residence, No. Farmington Mo. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED—HUSBAND OF (or) WIFE OF Mr. Samuel N. Nicholson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 18 - 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 3 3

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
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) Boonsdale Indiana

FATHER
13. NAME Mr. Wm. K. Ketchum
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER
15. MAIDEN NAME Martha Jane Luedenbach
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Ms. Georgia Bowyer (Daughter)

18. BURIAL, CREMATION, OR REMOVAL PLACE Park View - Farmington DATE June 28, 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin W. Hoot
Flax Run, Mo.

20. FILED June 21, 1940 T. J. Robinson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 21, 1940

22. I HEREBY CERTIFY that I attended deceased from May 14, 1940 to June 21, 1940
I last saw him alive on June 20, 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:
acute nephritis and cerebral hemorrhage
Other contributory causes of importance: 82 W

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? h

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? yes
If so, specify _____
(Signed) L. M. Stanfield M. D.
(Address) Farmington Mo

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 Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address Flax River, Ms

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.