

NOV 10 1940

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

35159  
Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 244  
(b) Township Central Primary Registration District No. 5338 Registered No. \_\_\_\_\_  
(c) City Paulsboro or Paulsboro (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. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Joseph Nicholson

(a) Residence, No. Paulsboro, Mo. R.R. #1 St.  (If nonresident, give city or town and State)  
(Usual place of abode; if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Christina Nicholson

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 1, 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
85 11 20

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) Virginia (STATE OR COUNTRY) 1

13. NAME Philip Nicholson

14. BIRTHPLACE (CITY OR TOWN) Penn. (STATE OR COUNTRY) 1

15. MAIDEN NAME Christina Cornick

16. BIRTHPLACE (CITY OR TOWN) New York (STATE OR COUNTRY)

17. INFORMANT Mrs Geo. Southard (ADDRESS) Buffalo Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Paulsboro Cem. DATE 9-22 1940

19. FUNERAL DIRECTOR (NAME) L. B. Jones (ADDRESS) Buffalo Mo.

20. FILED 10-12 1940 Mrs C. E. Reuch Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-20 1940

22. I HEREBY CERTIFY, That I attended deceased from 8-16 1940 to 9-14 1940

I last saw him alive on 9-14 1940 Death is said to have occurred on the date stated above, at 8 A.M.  
The principal cause of death and related causes of importance were as follows:

Nephritis (chronic)  
Every heart valve leading

Other contributory causes of importance: 1941

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 \_\_\_\_\_, 1940

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) V. H. Herment M. D.

(Address) Buffalo Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. E.—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.

1 X1695

RECEIVED

District Health Officer No. 7,

District File Number 11-40-1637

Date Filed 11-13-40

**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.....

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

Signed Lelyde Montgomery

Licensed Embalmer No. 3592

P. O. Address Buffalo Mo

**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.**