

REG 16 1940  
Registration District No. 200

Primary Registration District No. 4120

Registrar's No. 18

## 1. PLACE OF DEATH:

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

(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 23. (a) PRINT FULL NAME Mary C. Nicholson3. (b) If veteran,  
name war3. (c) Social Security  
No.4. Sex Female 5. Color or race White 6. (a) Single, widowed, married,  
divorced W6. (b) Name of husband or wife William Nicholson 6. (c) Age of husband or wife 85  
alive. 85 years7. Birth date of deceased Nov-19-1861  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
78 11 28 hr. min.9. Birthplace St Louis Rural Mo  
(City, town, or county) (State or foreign country)10. Usual occupation House wife

11. Industry or business

12. Name John Tilger13. Birthplace Germany  
(City, town, or county) (State or foreign country)14. Maiden name Rachel Beers15. Birthplace Phillipsburg Pennsylvania  
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Frank Nicholson(b) Address Molt Mo17. (a) Burial (b) Date thereof Nov 18 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Fairview18. (a) Signature of funeral director Leonard Fry(b) Address Kearney19. (a) 11/17/40 (b) John L. Street  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay  
(c) City or town Kearney  
(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.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17<sup>th</sup>  
year 1940 hour 4 minute 45 a.m.21. I hereby certify that I attended the deceased from  
1934, 1934, to Nov. 17, 1940  
that I last saw her alive on Nov 16, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic Myocarditis 1930  
Toxic goitre 1930

Due to

Due to b6AOther conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations noneOf 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?

82  
While at work? (Specify type of place) (e) Means of injury23. Signature H. R. Schumacher (M. D. or other) M. D.Address Kearney Mo Date signed 11-18-40

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 12-13-40

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**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.**

Registration District No. 200

Primary Registration District No. 4120

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

1. PLACE OF DEATH

(a) County Clay

(b) City or town Farmers  
(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

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary C. Nicholson

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH Month 7 day 17  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex F

5. Color or race W

6. (b) Name of husband or wife William

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

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 \_\_\_\_\_

8. AGE: Years 78 Months 11 Days 28  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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 (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11/17/1940 (b) Phos. L. Smith  
(Date received by registrar) (Registrar's signature)

Other conditions (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 J.R. Schumacher (M.D. or other) \_\_\_\_\_  
Address Rearney \_\_\_\_\_

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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