

No. 2
-1-
17

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **38546**
Registrar's No. **10**

Registration District No. **211**

Primary Registration District No. **5291**

1. PLACE OF DEATH:
(a) County **Cole County**
(b) City or town **Rural, Marion**
(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 **72 yrs**
(Specify whether years, months or days) **2**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Cole**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Near Marion, Mo.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **Viola W Nevins**
(b) If veteran, name war
(c) Social Security No. **no**

4. Sex **Female** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
(b) Name of husband or wife **Mart Nevins** 6. (c) Age of husband or wife if alive **Sept 22 1889**
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **72** Months **2** Days **8**
If less than one day, hr. min.

9. Birthplace **Boon County** (State or foreign country) **S**
House wife

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name **Hugh Murphy**
13. Birthplace **Virginia**
14. Maiden name **Harriet A. Murphy** (State or foreign country)
15. Birthplace **Maryland** (City, town, or county) (State or foreign country)

16. (a) Informant **Edna Thompson**

(b) Address **Marion, Mo.**

17. (a) (b) Date thereof **Dec 2 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **burial, New Hope Cem**

18. (a) Signature of funeral director **Bowlin Funeral Home**
California, Mo.

(b) Address
19. (a) **Dec 2-1940** (Date received local registrar) (b) **H. T. Leach M.D.** (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **11** day **30**
year **1940** hour **6** minute **-** M.
21. I hereby certify that I attended the deceased from **11-30**, 19**40**;
that I last saw her alive on **11-30**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic nephritis
Due to
Due to
Other conditions (include pregnancy within 3 months of death) **1/21**

PHYSICIAN
Major findings:
Of operations
Of autopsy
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?
While at work? (Specify type of place) (e) Means of injury
23. Signature **H. T. Leach M.D.** (M. D. or other) **MD**
Address **Marion, Mo.** Date signed **12-2-40**

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

RECEIVED
NOV 21 1940

STATE OF ILLINOIS
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38546

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 211

Primary Registration District No. 5291

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cole
 (b) City or town Marion T.P.
(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 Viola W. Nevins

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 m

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

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

8. AGE: Years 72 Months 2 Days 8 If less than one day _____ min.

9. Birthplace Marion Cole County Missouri
(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) Dec. 2-1940 (b) H. F. Leach, M.D.
(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 11 day 30
 year 1940 hour _____ minute _____ M.

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

Due to _____

Due to _____

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature A. L. Meredith (M.D. or other) _____

Address Prairie Home Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

