

FILED JAN 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **43249**

Registration District No. **75** Primary Registration District No. **4339** Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Monteau**
(b) City or town **Tipton**
(c) Name of hospital or institution: **Morgan Street**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **None**
(Specify whether years, months or days) **3**

3. (a) PRINT FULL NAME **Robert Melville Nixon**
3. (b) If veteran, name war **None** 3. (c) Social Security No. **330-18-8815**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife **--** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **August 18th, 1913**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
27 4 7 hr. min.

9. Birthplace **Tonopah, Nevada**
(City, town, or county) (State or foreign country)

10. Usual occupation **Clerk**

11. Industry or business **Grocery Store**

12. Name **M.L. Nixon**

13. Birthplace **Benton County Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Della Wear**

15. Birthplace **Benton County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **M.L. Nixon**

(b) Address **Donna Missouri**

17. (a) **Removal** (b) Date thereof **12/25/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Lincoln, Mo**

18. (a) Signature of funeral director **J. E. Richardson**

(b) Address **Tipton Mo**

19. (a) **12-26** (b) **Mr C E Fry**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Boone**
(c) City or town **Columbia**
(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 **12th** day **25**
year **1940** hour **1st** minute **A. M.**

21. I hereby certify that I attended the deceased from **Did not see him alive** 19____;
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Fracture ribs, Internal hemorrhage,**

Due to **Auto accident**

Due to _____

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) Accident, Auto**

(b) Date of occurrence **December 25, 1940**

(c) Where did injury occur? **1/2 mile west of Syracuse, Mo on highway 50** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Pro**

While at work? **no** (Specify type of place) (e) Means of injury **Auto**

23. Signature **Kenneth Latham** (M. D. or other) **Coroner**
Address **California, no** Date signed **12/25/40**

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

210 m
95

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed

Jenee-E- Richards
Licensed Embalmer No. 2466
P.O. Address Dipton, Ill

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. 43249

Registration District No. 575

Primary Registration District No. 4339

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Moniteau
(b) City or town Clinton
(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 _____
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Robert Melville Dixon

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 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 27 Months 4 Days 7 If less than one year _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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.

INTERNAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 25 year 1970 hour _____ minute _____ M.

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 Fracture Right Internal Hemorrhage Duration _____
Due to Auto accident
Due to collision with another
Due to Auto and then crashed
into electric high line pole
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations fracture Of autopsy _____

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? On highway # 50 near Syracuse, Mo.
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Kenyon Lathan M. D. - Coroner (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

S-43249