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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 14 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2065

Registration District No. 12 d Primary Registration District No. 3009 Registrar's No. 40

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town " "
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital ~~or institution~~ 6 weeks (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Gir 16
(c) City or town Millerville 0
(If outside city or town limits write "RURAL") 0
(d) Street No. " (If rural, give location) 1
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME America Nisivanger
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Female
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife John F. Nisivanger
6. (c) Age of husband or wife if alive years
7. Birth date of deceased November (Month) 15 (Day) 1864 (Year)

8. AGE: Years	Months	Days	If less than one day
76	2	5	hr. min.

9. Birthplace Marble Hill (City, town, or county) Mo. 0 (State or foreign country)
10. Usual occupation Housework
11. Industry or business
FATHER
12. Name Thomas Procter
13. Birthplace (City, town, or county) Tennessee (State or foreign country)
MOTHER
14. Maiden name Rebecca Brown
15. Birthplace Scott Know (City, town, or county) 9 (State or foreign country)
16. (a) Informant John F. Nisivanger
(b) Address Millerville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 22-41 (Month) (Day) (Year)
(c) Place: burial or cremation Cusel Heights
18. (a) Signature of funeral director [illegible]
(b) Address Cape Girardeau
19. (a) 1-20-41 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20th year 1941 hour 10 minute 11 M.
21. I hereby certify that I attended the deceased from Dec 5 - 1941, to Jan 20, 1941; that I last saw her alive on Jan 19, 1941 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Artero Sclerosis	10 yrs
Due to	
Due to	
Other conditions Fracture Left Hip (Include pregnancy within 3 months of death)	Dec 5-40
Major findings: Of operations	
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: 16
(a) Accident, suicide, or homicide (specify) 0
(b) Date of occurrence 0
(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? 2 (Specify type of place)
While at work? (e) Means of injury
23. Signature Dr. L. Deshaw (M. D. or other) D
Address Jackson Mo Date signed 1-20-41

(Licensed Embalmer's Statement on Reverse Side)

145
99

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 Lyman H. Sprinkle

Licensed Embalmer No. 1013

P. O. Address Cape Girardeau

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.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2063

Registration District No. 125 Primary Registration District No. 3009 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Gir (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 years, months or days)

In this community

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.

3. (a) PRINT FULL NAME America Niswanger

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 years

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

8. AGE: Years 76 Months 2 Days 5 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20 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 Arteriosclerosis

Due to

Due to

Other conditions Fracture left hip (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

(b) Date of occurrence Dec 5 - 1940

(c) Where did injury occur? Home, Millersville Mo. Rural (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Burn yard at home. (Specify type of place)

While at work? yes (e) Means of injury Fractured Hip FALL

23. Signature D. L. Seabaugh (M. D. or other)

Address Jackson Mo Date signed 4-10-40